# SOCIAL WORK IN HOSPITALS

## A CONTRIBUTION TO PROGRESSIVE MEDICINE

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To Dr. Richard C. Cabot
whose insight, constructive imagination, and fearless pioneer spirit have been the chief factors in starting and bringing to its present status in this country, organized hospital social service.

## PREFACE TO FIRST EDITION

IN THE winter of 1912 I had the interesting opportunity of visiting most of the hospital social service departments in this country. At that time I was impressed by the variety of types of organization, by the diversities in the interpretations of the hospital social worker's function, and by the great need for more adequately trained workers. In every department the paid workers were women. It was interesting to note, however, that in some instances men—especially medical students—were being drawn into volunteer service. I was even more impressed with the widespread interest that I found among physicians, hospital authorities, and lay people, in this new conception of the hospital's social responsibilities. If hospital authorities and physicians are persuaded that social work is needed as part of thorough treatment of the sick, surely the workers, in spite of their handicaps in training, in spite of the lack of standardization in their case work and in their organization, are meeting, nevertheless, a real need. Every department I visited seemed to me pervaded by a genuine spirit of service. Eagerness for information concerning all phases of the hospital's social problems was also notable among those actually engaged in the work. This very general desire,

and evident need for exchange of experience and for a more conscious and consistent effort to establish standards, has made it seem worth while to present this preliminary survey of the present status of hospital social work.

Suggestions have come to me from workers in various existing departments and from an interesting personal experience. To make acknowledgment to all who are responsible for material presented in this book would be impossible. The material has come to me in some instances unconsciously, but more often with the most generous spirit of helpfulness from hospital social workers, from physicians and institution executives, and also from many other friends of social service—among them the patients themselves.

I am indebted to my sister, Cornelia James Cannon, and to Miss Elizabeth V. H. Richards, Head Worker of the Social Service Department of the Boston Dispensary, with whom many of the subjects in this little book have been discussed.

Especially am I under obligation to Dr. Richard C. Cabot, whose stimulating leadership I have enjoyed for six years. He has read the manuscript and made invaluable suggestions. I am indebted also to Miss Mary E. Richmond, without whose stimulus and interest the book would not have been attempted.

Boston, October, 1913.

## PREFACE TO REVISED EDITION

WHEN this book was written in 1913 hospital social service had already been in operation eight years and there were approximately a hundred social service departments in the United States. These have developed steadily, some of them increasing a staff of two or three workers to twenty or more. In addition, nearly three hundred departments have since been established, making a little less than four hundred now in existence. While in 1913 we were still in a more or less experimental stage, beginning to see some of our functions clearly, but uncertain of the scope, organization, and future of medical-social work, such work is now accepted as an essential part of a modern hospital.

No one who is familiar with the present situation in hospitals, and especially with the social work carried on by them, would venture to be dogmatic on the subject. Nevertheless, many significant developments have taken place. Some methods will probably have to be modified but the principle is not questioned. This fact was officially recognized in the report of the survey of hospital social work made under the auspices of the American Hospital Association in 1920. During the past ten years important functions of hospital social work have

been defined and the principles of organization worked out through experience. Although these have been generally accepted by hospital administrators and social workers alike, and the necessity for specialized training has been recognized, adequate provision for such education has not yet been made.

Many leaders in clinical medicine now recognize the value of medical-social service to a large percentage of patients. A modification of the manner of life of the sick person, changes in his health habits, his co-operation in the plan of treatment, and the elimination of obstacles to such treatment are necessary at all economic levels. In conjunction with their private practice, physicians who appreciate the value of this service are turning to hospital social workers for discriminating knowledge of the various health and medical resources available to patients who can pay as well as to those who cannot, and for a type of social experience that they recognize as skilled. But whether or not a more general application of the service to sick people regardless of their financial status be developed rests largely with hospital social workers themselves.

The present experiments will be useful in so far as they are conducted with open-mindedness by forward-looking administrators and by social workers well grounded in the principles of hospital social service, particularly by those able to devise new methods by which to aid organized medicine in

its rapidly developing complexity. The advances that have already been made and the future that is so full of interesting possibilities give great significance to the present stage of hospital social work.

In the revision of this volume I have tried so to modify the text of the first edition, both by changes and amplification, as to make clear the present status and trend of the work in its application to and its integration with medical institutions.

IDA M. CANNON

Boston, March, 1923.

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# CHAPTER I

## INTRODUCTORY

THE hospital social service movement aims to throw a new light on medical practice in institutions. It seeks to understand and to treat the social complications of disease by establishing a close relationship between the medical care of patients in hospitals or dispensaries and the services of those skilled in the profession of social work; to bring to the institutionalized care of the sick such personal knowledge of their social condition as will hasten and safeguard their recovery.

The physician recognizes physical symptoms and seeks for the underlying causes of disease. The skilled social worker recognizes social symptoms of human distress and also seeks their underlying causes, that she may the more wisely help. Our large hospitals and dispensaries shelter many persons who need both kinds of aid. The services of doctor and social worker then become interdependent, just as the physical and social conditions of the patient are interrelated. This interdependence of medical and social work, not only in treatment but also in seeking the causes of disease, the hospital social service movement emphasizes. It strives to find the common ground of medicine

and sociology and to relate effectively the functions of doctor and social worker.

Pioneers in the hospital social service movement recognized in the hospital a new approach to such familiar human problems as broken homes, neglected childhood, and lives warped by industrial and economic pressure. With such questions thoughtful social workers in family welfare agencies had long been concerned.

As the problems of many hospital patients are social as well as medical, two expert professions, not one alone, are needed. Yet only within the last decade have the medical and the social worker been able to aid each other. Only within that period have they been able habitually to meet as experts, each teaching and each learning from the other: both united to serve the patient and the community. Both groups must recognize a common ground before they can reach a mutual understanding. So we find gradually developing a sympathetic interweaving of effort by two professional groups that for a time struggled separately with the problems of the sick and dependent in the community. Not only has it been demonstrated that medical and social interests are closely interrelated, but also that, in their technique, neither practitioner can reach a high quality of service unless each is excellent.

The social worker may destroy the value of a doctor's prescription by a faulty social diagnosis or treatment, and a doctor may no less effectively

vitiate an excellent social diagnosis or treatment. A patient for whom a back brace was ordered by an orthopedic surgeon was found subsequently by a social worker to be starving herself to pay for the brace. Later a general physical examination showed that she was suffering from pernicious anemia. One thing is certain: a patient with pernicious anemia will not long wear a back brace. Another patient, markedly debilitated, came to a hospital for a tonic, but received little benefit from the physician's prescription because she was struggling to care for herself and her young son on the $4.50 a week provided by a so-called "relief society."

In not every hospital can a medical-social worker be effective, however much of an expert she may be, *for medical-social work, to be effective, requires as a prime necessity good medical work.* If medical diagnosis is vague or faulty, no social work, however expert, can compensate for it. Hospital social work, as part of efficient medical practice, can develop, therefore, only in institutions where the medical work is progressively of a high grade.

Since 1905, the year of the initiation of the hospital social service movement in the United States, nearly four hundred social service departments, as has been stated, have been introduced into hospitals and dispensaries in this country. The term "social service" is still used rather indiscriminately to cover a variety of extramural activities of the hospital and many kinds of personal

service to the patients. While it would be unwise even now to dogmatize on the function, organization, or scope of hospital social service, we have behind us seventeen years of experience out of which we are beginning to formulate standards and discover guiding principles. In the pages that follow, an attempt has been made not to present a text-book on hospital social work, but to offer an interpretation of what the movement means to some of those most closely in touch with it.

## CHAPTER II

## THE BEGINNINGS OF HOSPITAL SOCIAL SERVICE

THE spirit of service to the sick is not new. Indeed the care of the sick has been an unfailing expression of human endeavor since the early Christian Church recognized the care of the bodies as well as the souls of its children to be a prime duty. Hospitals were established and nursing orders arose as a practical expression of the religious zeal that glorifies unselfishness. Victims of sin and suffering were sought in their wretchedness and served with tender, sympathetic devotion. Throughout the history of hospitals and the history of the Christian Church the spiritual welfare of the sick has claimed the attention of the clergy, and no hospital today is without their ministrations.

In our modern hospitals also there are many persons who recognize that the patient's needs are not entirely physical, and who contribute their share of cheer and comfort to the sick. Volunteer committees of women have for years visited patients in the wards of various institutions and extended their friendly offices. Busy doctors and nurses have done countless unrecorded acts of

kindness not demanded by the requirements of their professional duties. Thus, the patient's spiritual needs and his dependence on sympathy and affectionate interest have long been recognized both in theory and in practice.

There are, however, certain fundamental differences between these intramural attentions and the hospital social service which we are to consider. Formerly, neither priest nor friendly visitor cooperated closely and constantly with the doctor inside or with social workers outside the hospital. It has remained for the medical-social workers of the present day to supplement the function of the unofficial visitors with a fuller consideration of a patient's needs, and with a form of skilful service that is now accepted as an important element in thorough medical treatment.

Four important contributions have been made to the development of this new hospital social service, a service quite different from any that preceded it: first, by the society for the after-care of the insane in England; second, by the lady almoners in London hospitals; third, by nursing in its various forms; fourth, by the methods of social training which were given medical students in the Johns Hopkins Hospital as early as 1902.

The first of these contributions dates back to about 1880. The problem of the insane is a peculiar one, yet the principles on which the after-care of the insane was developed in England are of more than ordinary significance to general medical-social

service. The object of the English organization, known as the Society for After Care of Poor Persons Discharged Recovered from Insane Asylums, was to arrange for the care of discharged patients, especially those who were homeless, and to keep friendly supervision over them during the process of their readjustment to community life. This was always done in close co-operation with the medical superintendent of the asylum. The excellent work of the English society was the stimulus for a similar work on this side of the water in connection with the New York state hospitals for the insane. The sub-committee on the after-care of the insane, of the State Charities Aid Association of New York,[1] was formed about the same time that the hospital social service movement started in this country. The work of this committee may be accepted as the forerunner of the plan for after-care of patients which is now quite generally accepted as essential by hospitals for mental diseases in many states throughout the country.

2. The second and probably most important contribution to hospital social work came from the reorganization in England of the work of the lady almoners by Charles S. Loch (now Sir Charles Loch) when Secretary of the London Charity Organization Society. The post of almoner is an old one in many of the English hospitals. Mr. Loch saw

[1] See State Charities Aid Association of New York, Fourteenth Annual Report, November 1, 1906. Also later reports of its subcommittee on After Care of the Insane.

possibilities of usefulness in a reorganization of the almoner's function, and presented this suggestion in a paper published in London in 1892.[1]

> People talk of medical charity as if it were a thing apart, unlike all other forms of charity, to be regulated by no principles, to be bettered by no co-operation with others. . . . What more glaring picture of charitable impotence is there than that destitute persons should constantly apply to a free dispensary for drugs which cannot benefit them if they lack the necessary food? Or that, in the same illness, they should go from one out-patient department, free or even part-pay dispensary, to another without any heed being paid to their actual conditions? To be effectual, even to be equitably administered, medical charity must act in alliance with general charity. Their cause is one. Their difficulties are very similar. Each will succeed better with the help of the other.

How to prevent the abuse of medical charities (as they were then called) by those able to pay had long been a puzzling problem to English social workers and hospital boards. Mr. Loch saw the almoner's opportunity to inquire into the circumstances of a patient and check that abuse. But in practice her function soon grew to be much wider than that of mere "inquirer" or mere dispenser of charitable relief. The first lady almoner under the new plan was appointed in 1895 at the Royal Free Hospital in London in accordance with a plan outlined by Colonel Montefiore and Mr. Loch in 1890. Their plan as presented to the Select Committee

[1] See Loch, C. S.: "The Confusion in Medical Charities," *Nineteenth Century*, Vol. XXXII, August, 1892, pp. 303–304.

of the House of Lords in 1890 was as follows:

> There should be appointed in every medical charitable institution a distributor or referrer of patients, who should see the patients after they have been seen by the medical officer, and who, subject to the requirements of the hospital from the point of view of medical instruction or gravity of illness, should decide as far as possible on the statements of the petitioners for relief, and also as a rule, by a reference of the case to a charity organization committee or some proper local organization.

The lady almoner was then to decide whether the patient's social condition indicated that both medical and social relief were more suitable under poor law provision, or whether he had best be cared for at the private hospital to which he had applied, or whether he ought to provide for himself by going to a private medical practitioner. On this plan, each applicant at the hospital would receive relief on his first visit, if necessary; medical requirements, from the point of view of education, would be met; the social circumstances of the patient would be taken into account, no less than the medical; and other than medical relief would be forthcoming for those that require it.

In England the hospital was conceived as a link in the chain of charitable institutions and organizations, and the lady almoner was regarded as the expert ready to bring to hospital problems a knowledge of community resources and a mind trained in methods of social work. She has been described by the secretary of a London hospital as "a lady who has had a period of training in social questions

generally, and especially in the various organizations of charitable help. She knows all about Labor Bureaus, Emigration Societies, Sick Room Aid Societies, Prevention of Cruelty to Children Societies, Discharged Prisoners' Aid Societies, Home Nursing Associations, Convalescent Homes, Societies for the Prevention of the Spread of Phthisis, Provident Dispensaries, Poor Law Infirmaries, Apprenticeship Associations, and so on."[1] Before 1905, the date that America entered this field, many London hospitals already had the services of a lady almoner.

3. In regard to the work of the nurse, it is difficult to measure how far her varied services have contributed to the hospital social service movement. Long before the type of work which we are considering was established she was an accepted part of medical care in the homes of the sick poor. Usually attached to some charitable society, her function was at first conceived as distinctly medical—the provision of skilled nursing service to patients in their homes. She soon found, however, that nursing the sick and poor in their homes was very different from nursing in hospital wards. The thoughtful visiting nurse realized her need of more social knowledge and early called attention to the common field of the medical and the social worker.

The early type of visiting nursing which most resembled present hospital social work, though

[1] The *British Medical Journal* (Supplement), February 5, 1910, p. 1.

quite distinct in its function, was that of the nurse attached to a hospital or dispensary who visited dispensary patients and those discharged from hospital wards in order to extend nursing service into the homes, and thus to assure more satisfactory results from the medical and surgical work done by the hospital.

The few progressive hospitals that extended this visiting nursing service into patients' homes offered to pupil nurses in the training schools experience in such home nursing. For example, in 1904 the Presbyterian Hospital in New York sent student nurses attended by an instructor to visit the homes of the hospital and dispensary patients. The course was elective and covered two months. Student nurses were "taught to give nursing care, to improve hygienic conditions, and to aid and encourage the patients by kindness and helpful advice." Thus, those who left the hospital while still needing surgical dressings were kept under supervision. Tuberculous patients, sick children, and other persons received hygienic instruction and were kept in touch with dispensary physicians. With an increasing recognition of the need for social work in connection with this medical service, the Presbyterian Hospital appointed a special nurse in 1907 to supervise the social aspects of the nursing service. This experience also was offered as an elective course covering two months for the pupil nurse. The visiting nurse was thus an important pioneer in the great public health nursing move-

ment which has in the last decade fostered the public health campaigns against tuberculosis and infant mortality and the promotion of school hygiene.

The social training given Johns Hopkins medical students was, however, the most significant contribution to the development of hospital social service in this country. Dr. Charles P. Emerson of that University recognized that truly effective medical training must include an understanding by a physician of the background and the standards of living of his patients. Dr. Emerson describes the development of his work as follows:

> It was partly to aid their education that seven years ago (1902) some of the medical students of the Johns Hopkins University organized the first student board of the Charity Organization Society of Baltimore. They visit one poor family or at most two poor families, assigned them by this society, for weeks, months, or even for four years. They do what they can to improve conditions in those households. No effort is made to select for these students families in which there is sickness; in fact, the students prefer families where there are boys. But the students learn how the poor man lives, works and thinks; what his problems are; what burdens he must bear. They learn the intimate relationship between the ills of the physical body and the home environment. They also learn how easy it is to give very good advice which will add burdens that cannot be borne. They find out that the poor man is not always a self-convicted sinner nor a self-confessed ignoramus, and that he has his own ideas as to the necessity, and especially as to the possibility of his following advice. The poor man loves his vices as truly as does the rich man, and will not abandon them at the off-hand suggestion of a strange doctor. The students find that to effect a much

needed reform, e. g., to keep the windows open, they must win first the confidence, next the love of the poor patient, and then stick to him closer than a brother to prevent relapses. . . In five years there were on the rolls of active volunteer workers of the three students' boards over sixty students, or one-quarter of the entire enrollment of the school. They do not meet in the hospital, but in the offices of the Charity Organization Society. The reason for this was that every member of the self-appointed committee which guided this work was connected with the hospital and was also a manager of the Charity Organization Society, hence no conflict between these two interests could arise. All the patients at this hospital who seemed to need special social service were referred directly to this society, but the most interesting and the best cases for the students to study are not these medical cases. This organized student work, with its purpose of training doctors in social service, is, we believe, a very important department of the hospital.[1]

Dr. Emerson's valuable work differed from present hospital social service in that he was aiming to educate medical students, not primarily to serve hospital patients. His students visited many who were not sick, and their work had no special application to the medical clinics.

These four expressions of social interest were to be found in varying degrees in many hospitals previous to 1905. That year, however, saw the organization of a social service department in a dispensary and the beginning of organized and trained social work in medical institutions in the United States. It is well known that to Dr. Richard C. Cabot of Boston is due the credit of introducing the

[1] Emerson, C. P.: "The Social Service Department of a General Hospital," *National Hospital Record*, March 15, 1909, pp. 5–7.

social worker as a definite factor in hospital and dispensary treatment. Not alone for the sake of the patient's spiritual welfare, not for the training of medical students, not for the instruction of nurses, nor simply for the extension of medical care into the homes was this form of work created. Rather was it conceived by a physician who, in seeking the improvement of dispensary practice, found in the social worker a potent means for more accurate diagnosis and more effective treatment. Miss Garnet I. Pelton, the pioneer hospital social worker, helped to lay the foundation of the first social service department—that at the Massachusetts General Hospital.

Hospital social service as we are to discuss it in this book brings into consideration a worker whose function is not distinctly medical. While she must have an understanding of the patient's physical condition, the physical condition is only one aspect of the patient of which she must take account. As the physician sees the diseased organ not isolated but as possibly affecting and being affected by the whole body, so the hospital social worker sees the patient not merely as an isolated, unfortunate person occupying a hospital bed, but as a member belonging to a family or community group that is altered because of his ill health. Physician and nurse seek to strengthen the general physical state of the patient so that he can combat his disease. The social worker seeks to remove those obstacles, either in the patient's surroundings or in his men-

tal attitude, that interfere with successful treatment, thus freeing the patient to aid in his own recovery. In this way the hospital social worker finds in the hospital an opportunity for supplementing and reinforcing medical service. Wherever hospital social workers have been able, for the sake of thorough, effective treatment, to relate their efforts most closely to those of doctors, nurses, and hospital authorities on the one hand, and to outside social agencies on the other, they have found their greatest usefulness. They have demonstrated that there is in medicine a place for trained workers who devote themselves to the study and understanding of social distress, which, no less than physical disease, disturbs and cripples human lives.

I have said that the spirit of service to the sick is not new. Before proceeding to those practical details of medical-social work with which this book is especially concerned, it may be well to return to the hospital and nursing background against which all these details must be measured and without which their relation to progressive medicine cannot well be understood.

## CHAPTER III

## THE HOSPITAL BACKGROUND

THE story of the Christian nursing orders, down to the organization of the Sisters of Charity under St. Vincent de Paul, is one of devotion and service to the sick which we may never hope to surpass, however much we may excel those earlier workers in scientific medical knowledge. Yet in the last quarter of the eighteenth century, John Howard, in reporting the conditions he found in the prisons and hospitals of England and France, revealed a black page in the history of medicine and nursing. His report not only disclosed the ignorance and superstition that shrouded much of the medical practice of that day, but it described institutional conditions so unsanitary as to be revolting, and personal care of the sick so incompetent as to be intolerable.

The picture that he drew is in striking contrast not only with the hospital of today but also with some of the earlier types of hospitals in which the dependent as well as the sick were welcomed and treated with tenderness and skill. The reforms in medical service for which Howard pleaded and to which the Fliedners of Kaiserswerth, and later, Florence Nightingale, made such valuable contri-

butions, probably could not have been accomplished except by just such vigorous measures as we see in the rigid discipline of the modern training schools for nurses.[1] Coincident with the reforms in nursing came marvelous changes in medical science. Out of this experience the modern hospital has evolved an institution complex and technical, prepared to care for physical ills through the scientifically trained physician and nurse.

Diverse factors have contributed to the mechanical efficiency, as well as to the growing popularity of hospitals. The administration of anesthesia, the application of asepsis and antisepsis, the laboratory as a diagnostic factor, the wider use of such therapeutic measures as X-ray, hydrotherapy, massage —all the modern refinements of medicine, surgery, and nursing, and the team-work necessitated between the practitioners of these different branches —emphasize the economy of grouping many forms of medical treatment in one institution. The dangerously rapid enlargement of our cities, with the overcrowding in wretched tenements, the poverty, weakened vitality, and disease that comes with such growth requires hospital treatment for an increasing number of people not well cared for at home. Another factor which contributes to a larger attendance at hospitals is the diminishing prejudice against them. The public sees constant evidence of their improved care of the sick. The

[1] See Nutting, M. Adelaide, and Dock, Lavinia L.: A History of Nursing, Vol. I, pp. 23 sq., 505 sq., 517–524. Also Vol. II, Chapter I. New York, G. P. Putnam's Sons, 1907.

attitude of the mother who leaves her child in the hospital is now less often one of despair than of hope. Patients who have been treated with kindness and skill have helped to establish in the community a justified confidence, which has on its part augmented the demands on the capacity of hospitals. But it should be added that these are no longer places for "the poor" only. The advantages and conveniences of hospital care in cases of surgery and obstetrics, and the shortage of trained nurses for private practice have greatly increased the use of hospitals by people of every economic status. Furthermore, the medical students' observations, gained through their ward experience, of the benefit received from diverse forms of treatment offered in a hospital, influence them, when they become physicians, to give their private patients this institutional care.

During the rapid material expansion of hospital accommodation, the attention of the institution officers and trustees has quite naturally been concentrated on the economic and quasi-military aspects of the organization and on the problems of properly housing and caring for the large numbers of patients applying for admission. But with the enlargement of the hospital and the increase in administrative work has come a division of function. The technique of administration developed in the business world has, in recent years, been more and more applied to medical institutions. Details of management, such as the investment of funds, pur-

chase and distribution of supplies, employment and supervision of the large corps of employes, care of the plant, running of the laundry, providing food, regulation of the dietary, and bookkeeping, have necessitated careful business organization. This has engaged the attention of superintendents and trustees. They have been setting their house in order and have had little time to study the public which not only relies upon hospital service but supports it. The medical work of a hospital and its relation to the actual needs of the sick who apply for its care have been to a great extent passed on to physicians and nurses.

But the staff of physicians and surgeons has been organized, not for a sensitive appreciation of what the public needs, but to promote efficient and consistent technical service and to assure authoritative control of the medical work within the hospital. Training schools for nurses, with their rigid organization and severe discipline, have been absorbed in the difficult task of getting the day's work done in the wards and at the same time maintaining professional courses.

The large modern hospital with its elaborate organization and system has become so like a great machine that the uninitiated are usually oppressed by it. The mechanism is baldly apparent, while the reason for its existence is often obscured. This obscurity is discouraging not alone to the outsider who knows nothing of hospital life and organization, but too often to those who are a part of it.

System and organization are necessary; indeed, those who really understand the problems of hospital administration realize that there is need for even better and more extensive application of business principles in our institutions than at present prevails, and that not until the machinery runs smoothly can a hospital reach its most effective medical service. Nevertheless, smooth-working machinery cannot alone produce a successful hospital, any more than an imposing edifice, beautiful chimes, cushioned pews, and a creed can produce a church.

Because attention has been concentrated upon internal development, the hospital has faced the danger to which all big institutions are susceptible —that of becoming unduly self-centered. Yet the fact that it exists primarily for the community makes it, perforce, an institution the social aspect of which no technical efficiency should be allowed to obscure.

While the hospital management may be unconscious of its social significance, the ultimate test of its usefulness is the flexible adjustment between its perfected machinery and the changing needs of the community from which its patients and its financial support are drawn. The rapidly growing interest in the development of medical-social service among hospital administrators is evidence of the fact that the old type of hospital whose sole objects were scientific equipment, medical skill and organization is not wholly satisfactory. Indefinite

and variable as the conceptions of social service are, there is still, in the desire for it, a consciousness of social responsibility which interrupts the complacency of the self-centered and self-satisfied institution.

Not until hospitals had solved the question of economically boarding and lodging the patient, not until they had intelligently dealt with his physical ills, could they see that many failures in treatment were due in part to elements lying outside the limits of conventional medical practice. In these latter days the candid critic has arisen who, in estimating the efficiency of hospitals and dispensaries, asks whether the treatment prescribed is carried out at home; whether advice given by the doctor is based on an understanding of the patient's financial status, family life, and general intelligence; whether there is a sufficient search for causes of disease more remote than those found in physical examination or under the microscope—in short, whether the hospital is merely treating the sick or is sincerely attacking their diseases by going to the root of their troubles. Such self questionings disclose a developing social conscience on the part of many who are engaged in medical service.

It is also notable that the social worker's recognition of disease as one of the outstanding causes of human misery indicates her growing appreciation of the social significance of medical work. The common connection between sickness and poverty has long been recognized as more than a

coincidence. The social worker, attacking fundamental problems of modern social life, has often perceived that he is hopelessly handicapped without the aid of the medical fraternity. He is beginning now to act upon this perception. Medicine and social work have always been in need of mutual help and understanding, but today they recognize that they must plan and execute their work together if the modern public health movements, so conspicuous a feature of our time, are to succeed.

If we are to understand the hospital social service movement we must know something of hospital organization, standards, and ideals. Let us consider as a type a large general hospital with a visiting staff of physicians and surgeons, with resident physicians, laboratories, and a nurses' training school.

The staff physician or surgeon who gives time and skill to the service of the hospital finds there a satisfaction in the exercise of his professional abilities. His skill is constantly being tested, his wits challenged. Each patient presents to him a more or less interesting and complicated problem. He may or may not be conscious of the human significance of his success or failure, and yet may deal superbly with the patient's disease. Because of his unusual technical qualifications, the physician is the most important element, not only in the medical treatment, but in the teaching of house officers, students, and nurses. Hence the hospital

largely revolves around him, and in distinctly medical affairs his position is often that of an autocrat.

The house physician, or interne, seeks hospital service as a final preparation for his professional life. He is ambitious to test what he has learned in medical study and to obtain valuable practical experience. Under the supervision of the visiting staff whose ability he respects, he acquires knowledge that cannot be found in books. But naturally the pressure of duties upon him and his intense interest in the technical side of the work lead him to concentrate on the strictly "clinical material" before him. He usually finds a great and engrossing satisfaction in his growing power to understand and combat disease and in his increasing responsibilities. Because of urgency of work, or lack of experience, or as a reflection of his chief's attitude, he may give little attention to the mental and environmental aspects of his patients' lives.

It is upon the nurse, however, that hospital life and atmosphere stamp themselves most definitely. She subjects herself to the discipline of the training school as a necessary preparation for the profession she has chosen. Once admitted, she must, if she wishes to remain, subordinate herself to all the regulations of school and hospital. At a very impressionable period of her life she spends almost every hour of three years within hospital walls. During these three years her mental processes are directed into conventional grooves. Her work is exacting and fatiguing. In most training schools

of good standing the discipline, as has been noted, is semi-military; there is more self-repression than self-expression; more emphasis on conforming to a technical standard than on the development of individual power. She is taught an intelligent use of her hands; also to observe carefully signs of physical changes in patients; and she is given a practical though superficial knowledge of the course of disease and of its treatment. In some training schools there seems to be a tendency to forget that nursing is supposed to be an art. Pressure of work is so great that little time is afforded for the niceties of nursing practice.

In proportion to the innate imagination and sympathy possessed by the woman—vital qualities that can be stifled but not killed—the human interest of the nurse survives. Yet it is almost impossible to keep one's attitude toward any familiar object fresh and sensitive. Oft repeated action tends strongly to become unconscious habit. The nurse who is under the stress of great physical fatigue, under the "illusion of routine," must gradually come to take much of her work as a matter of course. While she is gaining in technical skill she is fortunate, indeed, if by the same process she is not losing some of the human alertness and responsiveness which she had before coming to the hospital.

Here, then, are the visiting staff, the resident physician, and the nurses, all parts of a smooth-running machine, ready daily to care for the sick

and suffering. But what of the patient? The patient's point of view is in sharp contrast to that of nearly everyone he meets. All about him he sees people who appear to be indifferent where he is excited, comfortably unconscious of his pain, swiftly and easily passing him through their hands as a sailor coils a rope. To this big, strange place he comes, absorbed in the realization of his own danger and discomfort, only to find that he is one of many, a small part of a confusing whole. He is fortunate if he can enter into his hospital experience with a knowledge of the language and with some spirit of adventure to meet the incidents of life there. Too often, however, he is expected to conform to rules and standards which he does not comprehend and to which he sometimes cannot quickly adjust himself. Fortunately, his residence and experience in the hospital often give him an appreciative understanding of the whole régime, and he leaves, especially if he has had the good fortune wholly to regain his health, with a sense of gratitude for what has been done for him.

Obviously the hospital is a permanent, consistent organization regulated by deep-rooted conventions. The ever-shifting troops of patients form the unstable, non-resisting element—the inchoate mass of material that must be made to fit into a more or less rigid, well-ordered routine. They come to the hospital as individuals, but the tendency is to consider them in mass. And yet taking them in the mass, in the constant presence of pain

and suffering, there exist among them marked contrasts of ability, human frailty, intelligence, courage, and hopefulness.

The hospital population may be viewed from many angles and be as variously interpreted. The mind accustomed to consider disease as a factor in social maladjustment sees in the train of all this sickness, conditions possibly causal, possibly contributory, which are more closely related to the illness of the individual than the medical specialist is likely to perceive. The shattered limb which means to the surgeon merely a demand upon his skill, may have social significance because the result of an industrial accident that could have been prevented, and likely to be attended by the tragedy of unemployment and family dependence. The nurse, seeing in the recovery of the desperately sick "typhoid" the justification for her devoted service, may have little conception of the real significance of her work in preserving unbroken family ties—the father restored to the support of his family or the mother to the care of her children. The pathologist may see in the smear of impoverished blood merely a routine laboratory test, yet it may be the climax in the story of a girl forced into factory life to add a pittance to the meager income of a deserted mother.

The hospital, in fact, presents ample material for a social as well as a medical clinic. Here it is that one observes every type of social distress—a veritable congregation of "assorted miseries." All

these complications have been recognized theoretically by many hospital authorities, but practically ignored as needing treatment in their urgent effort to care for physical ills. Many medical and social workers who are thoughtfully searching for the causes and treatment of human misery ask whether or not the hospital is ready for a broadening of its function; whether or not it should now look with a larger sense of its opportunity and of its responsibility beyond its walls to the community which it more or less consciously serves. Well may these inquirers pause to consider the real reasons for the hospital's existence and the extent to which the patients who fill it are there through the results of accident or their own unfortunate ignorance, or through the careless indifference of society to the promotion of its own healthfulness.

Some thoughtful physicians are recognizing that in hospital and dispensary work they often do not get the results they work for, and they believe that this failure is partly due to defects in hospital methods. What conditions of hospital and dispensary work today require supplementing in order to produce effective results? An analysis of some of the characteristics of hospital diagnosis and treatment may help to show what the defects are and how they may be remedied.

Physicians on the staffs of our large dispensaries have more or less consciously accepted two different standards of medical work: one, that of private

practice—the careful examination of the individual patient; the other, that of the overcrowded modern clinic where a hasty, incomplete inquiry is all that can be given to a large majority of the sick. In a hospital, physicians usually limit the study of a patient to purely physical factors, a limitation which no conscientious physician would countenance in private practice. The hospital offers him its assistants, its laboratories, and the instruments necessary for accurate medical diagnosis, but these facilities do not provide for the attention to those other elements in human beings which the best private practitioners deem of great importance.

The elements in the complex personality of any human being have been characterized by William James as " the material me, the social me, and the spiritual me." "A man's me," he continues, "is the sum total of all that he can call his, not only his body and his psychic powers, but his clothes and his house, his wife and children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank account."[1] Many of these aspects of the "me" play an important rôle in disease, and yet may be overlooked in the swift routine of an out-patient clinic. Any deep cut or wound in the self, whether it be a disturbance of health, emotions, or finances, means a change in the whole man.

[1] James, William: Psychology, Briefer Course, p. 177. New York, Henry Holt and Co., 1892.

All these aspects of the patient's self the doctor in private practice attempts to understand, in order to be wise in his medical treatment and successful in his practice. He knows the temperament of his patient before he decides upon the rest cure or the work cure; he recognizes the patient's religious beliefs before he prescribes a dietary; he learns the family finances before he advises a trip to Florida.

Human beings have more points of likeness than of difference. Our instincts and our passions, our impelling desire for self-preservation, our love of family and friends, our reverence for God or for an ideal, form an heritage which men and women the world over hold in common. Each is profoundly modified, to be sure, by varying inherited traits, traditions, and standards of living and circumstances. The differences, because they are differences, stand out in our consciousness as of first importance and tend to blind us to the likenesses. But if we are to work intelligently with people in trouble, we must understand both the likenesses and the variations, and such understanding can come only with sympathetic observation and study.

It is easy to understand that the busy physician can study these surprising identities or modifying idiosyncrasies of character and experience in hospital patients in none but a superficial way. While the care of patients in a hospital ward offers more opportunity for observation of physical conditions than the dispensary clinic, there are in both ser-

vices limitations of time and a constriction of the field of attention which mark the difference between a physician's private practice and his hospital service. The limitations of time that affect the observation of a hospital patient's physical condition can be corrected by better organization of medical service. This is not, however, our present concern. The correction of the other limitation, that of the field of attention, calls for the co-operation of one skilled in understanding social problems and equipped by training and experience to guide a patient in solving those personal ones that may arise from his illness or to which his illness may have been due in part. Thus, the medical social worker becomes a component part of organized medicine.

# CHAPTER IV

## MEDICAL-SOCIAL PROBLEMS IN SOME OF THE INFECTIOUS DISEASES

TUBERCULOSIS. SYPHILIS. GONORRHEA.

A STUDY of hospital social service throughout the country and observation of group meetings of hospital social workers from many cities reveal a striking uniformity in the kinds of problem that patients present. On the contrary, the development of community social agencies, and the extent to which helpful resources may be used for hospital patients, vary greatly in the different cities and states, as do questions of organization within the hospitals themselves. But wherever the well-trained hospital social worker is placed, she finds such human difficulties as convalescents discharged to unsuitable homes or heavy responsibilities long before they are fit to return to them; the husband and the father of little children who is suddenly stricken with the knowledge that he has tuberculosis; the victims of chronic and incurable disease, for whom long-time care and often support is imperative; homeless men, sick and unable to work; lone young girls facing dishonored motherhood; women overwhelmed with nervous illness; the feeble of mind and those with mental disease who

cannot adjust themselves to family and community life; those physically handicapped for industrial life by disease and accident; the hunted slaves of some drug habit; others who in black despair have attempted suicide. The patient's social difficulty may be acute or chronic; it may be curable or incurable, according to his character and circumstances and the skill of the social worker. Recognizing these facts, to the skilled social worker each patient presents not only a medical problem but a social one. She tries sympathetically to understand his point of view as well as to make discriminating search for those factors in his life, habits, and environment which bear on his present trouble. She is intelligent and persevering in carrying out *with patient and physician* a medical-social plan for adequate treatment. It is here that the social worker who sees the implications of her task uses her resourcefulness most fully.

The hospital social worker should bring to her day's work not only the seasoned experience that enables her to advise and guide, but a freshness of vision which recognizes that to each patient his problem is exceptional. The capacity for putting oneself in another's place, and at the same time seeing the situation objectively in the light of accumulated knowledge of similar situations, should be treasured as a most precious asset by any one responsible for social case work. The worker who is unable to do this and who becomes a routinist, fails in large measure to express the purpose of

social service. One hospital social worker of long experience who, under pressure of work and fatigue, found her sensitiveness to the patient's point of view becoming dull, deliberately spent a few minutes each day watching the long line of sick people waiting for admission, and tried to imagine just how the hospital must impress each of them, and what fears, hopes, discouragements, and faith they were bringing to this new experience.

In the discussion of types of medical-social problems which follows, it should be remembered that while some generalizations have been yielded out of accumulated experience, each man or woman presents not only unique medical complications but unique social ones as well.

## THE TUBERCULOUS

Medical science has discovered a great range of physical manifestations of tuberculous infections. But the treatment of tuberculosis, whether it is lung, bone, gland, skin, or laryngeal tuberculosis, includes the establishment of an hygienic regimen. "Rest," "fresh air," and "good food," "hygiene" and "light work" are customary prescriptions. The social worker, however, must beware of any clumsy application of general hygiene rules. She should be sure to get from the doctor a clear understanding of the specific advice in each case, and then set herself to make the following of that advice possible and practicable. The simple therapy for tuberculosis is often very difficult to estab-

lish, as it frequently necessitates radical changes in habits of living.

The worker should have an intimate knowledge of the resources that local community and state offer for the treatment of tuberculosis; the types of cases admitted to hospitals and sanatoria; the methods of securing admission; the kinds of care that a patient will receive while there; and the facilities for supervision after discharge. This knowledge of facilities should include sanatoria, public and private, state and local, tuberculosis classes, anti-tuberculosis societies, dispensaries, and public health nurses. Often the physician in a hospital or dispensary may not know personally about these various aids. It is the business of the social worker to have this knowledge and to use it with discrimination.

Sometimes the doctor's advice may be modified by social facts disclosed by the worker's investigation.

A woman of forty was referred who was found to have incipient tuberculosis, and sanatorium treatment was advised. The social worker talked with the patient, visited the home, conferred with the husband, and then brought to the doctor for consideration the following facts: The home was a single house with four rooms in the outskirts of the city. There were no children. The patient was intelligent and very eager to do her part in the treatment, provided she would not have to break up her home. The husband, while fond of his wife, had caused her considerable anxiety by occasional drinking. A previous history of hospital care for the wife had resulted disastrously, for he had become involved with undesirable

companions. The man had been critical of his wife's inertia, which the social worker could now explain to him as due to her physical condition. When he understood, he was willing and glad to pay to have the laundry and cleaning done by a neighbor, if the patient would try home treatment. As a result of this consultation, the patient was recommended by the doctor for admission to a tuberculosis class. She followed directions faithfully, reported each week at the class meeting, and after two years was discharged cured. Now, after ten years, she is still well, doing her own work, and the home has throughout this time been kept intact.

The hospital social worker frequently has the duty of breaking to the patient the sad news of the diagnosis, or at least of explaining to him what the doctor's diagnosis means, and of interpreting to him a plan of treatment that may promise recovery instead of the doom which seems to him inevitable. It is at this psychological moment that she is often able to establish that friendly relation with the invalid which is the best possible basis on which to develop a plan of treatment.

Physicians and social workers who have had experience with cases of tuberculosis realize that what can be done for each individual seems to depend less on the state of the disease than on the character and temperament of the patient, his capacity to receive instruction, and the community resources for proper treatment.

A weak-willed man with a fretful and despondent disposition was sent to a social service department with a diagnosis of incipient tuberculosis. After much effort the patient's family was provided for so that he might go to a sanatorium where, the doctor said, the disease might be arrested.

He stayed there two months, idle and resourceless after an active life, complaining and worrying the entire time; then left against advice and returned home, where he died a month later.

Another patient, a colored porter, emaciated but with fire in his eye, was pronounced "advanced tuberculosis—not a hopeful case." He was too ill to be admitted to the sanatorium, for only incipient cases were accepted. He was, however, ready to make a fight. Admission being secured to a tuberculosis class, he followed explicitly all directions, slept out of doors even in the coldest weather, and accepted in a wholesome spirit the aid that was provided for his family. After a year and a half he was able to work. For fourteen years he has himself provided for his family. He has also demonstrated practical lessons in hygiene that have influenced a whole neighborhood.

The possible social complications of tuberculosis are many, due largely to its infectious nature and its chronicity, though a further difficulty is that it strikes heavily on young people just beginning industrial life. The invalid may be a member of a family, where the infection of little children is a serious danger; he may be a workman in a crowded workshop or factory where careless habits endanger others; or he may be handling food which is sold to an unsuspecting public. As a wage-earner his illness may deprive a family of support. All these disturbing factors make social service necessary if treatment is to be intelligently carried out and prevention of the disease to be extended.

Perhaps one of the most tragic situations that arises in dealing with the tuberculous patient is that of the foreigner who has come from country

districts in Europe, expecting to work in our factories and save enough to bring his family to this country. The following story is not an unusual one:

An intelligent young Greek, tall and broad shouldered, was one day sent to a social worker with a diagnosis of moderately advanced tuberculosis. His eyes betrayed his despair, but his story could be procured only through a countryman, another patient, who interpreted for him. He had been a shepherd on the hills of Greece. Upon his arrival in America he had gone to one of our mill towns hoping to earn enough so that his family might join him. His hopes, his ambitions, his young vigor became a tiny cog in the great machine of industry in an American cotton mill. In order to save all the money possible he shared a room with six other Greeks in a cheap boarding house. Discovering a night school by chance, he attended for several weeks the classes in English, and was making rapid progress when he became ill. He then went to a dispensary where a diagnosis of tuberculosis was made. His eight months in the United States entitled him to no free sanatorium care. When he found that there was little chance of obtaining medical aid except as a state charge, "a pauper," and that dependence on the state meant possible deportation for so recent an immigrant, he decided of his own accord to go back to his home. With the little he had been able to save out of his earnings, supplemented by some gifts of his associates in the mill, he purchased his transportation. Knowing that the tuberculous patient is a dangerous fellow-passenger, and that the disease he was taking back to his Greek home might carry disaster with it, the social worker consulted a Greek physician, a friend of the social service department, who offered to instruct the patient and to direct him to a physician near his home in Greece. Somewhat later the social worker received a letter, a number of the words written laboriously in English but much of it in his native language, which an-

nounced his safe arrival at home. The rest of the story she has never known.

So it is that our tenements and our industries are constantly sending to the countries of Europe these carriers of infection. Thoughtful social workers cannot have a part in such incidents without becoming restlessly conscious that these procedures not only fail to solve our tuberculosis problem and that of the infected immigrant, but that they create a grave problem for the country to which he returns.

Leaders in the anti-tuberculosis movement have for several years emphasized the importance of segregation of tuberculous patients. It has been generally accepted that in this method of dealing with infectious cases lies, in large part, the solution of the tuberculosis question. Experience has shown, however, not only that complete segregation is practically impossible, but also that in itself it generates problems. The enforced idleness in our present sanatorium régime, the development of the out-of-work habit, and the abrupt change from this abnormal life to strenuous home activities on discharge from the institution, all present difficulties that tax to the utmost the ingenuity and optimism of tuberculosis workers. Occupational therapy, greatly extended and developed during the war, has been practically applied in sanatoria for tuberculous soldiers. It is to be hoped that methods there worked out will in time be generally adopted in our civilian tuberculosis sanatoria.

Suitable occupation for those under treatment,

with graduated manual labor as recovery progresses and then careful supervision after discharge, during the period of readjustment to normal life, are now recognized as essential to thorough treatment. Little real progress has yet been made, but all of these questions are receiving the serious consideration of physicians, tuberculosis nurses, and social workers.

With the after-care of sanatorium inmates the hospital social worker is especially concerned. Until sanatoria have their own social workers for the after-care of discharged patients it is important that hospital social workers keep in touch with those persons for whom they have arranged institutional care. Only by careful study of results can the present expensive treatment of tuberculosis be fairly tested.

Many of the social implications of the fight against tuberculosis were recognized by social workers before the medical profession was aware of their significance. But most of them cannot, it is plain, be solved without the helpful working together of those who are treating the physical side of disease and those treating its social side.

No city or state has yet mastered its tuberculosis problem, although heroic efforts are being made the country over to do so, and in many states a reduction in the death rate of the disease is evident. Sanatoria and dispensaries are rapidly being extended under state and local boards of health. The old terror of "consumption" is gradually giv-

ing way to an attitude of confidence when the disease is treated early. The general hospital and dispensary still offer one of the most important opportunities for detecting the presence of phthisis.

The hospital social worker, spurred on by her patients' needs, should become a teacher who gives specific instruction to them and their families in wholesome, hygienic living. By using the fruits of her accumulated knowledge she can also bring pressure to bear assuring more adequate provision for those with tuberculous infections of various types. Lessons learned from these victims of preventable disease, sympathy for their losses and shattered hopes, should strengthen her purpose to do all she can to advance knowledge of disease on the one hand and to remove its causes on the other.

## PATIENTS WITH SYPHILIS OR GONORRHEA

In a survey of social service departments made in 1916, it was found that, out of 126 departments, 50 were concerned with social problems involving the treatment of syphilis, 31 with adult patients who had gonorrhea, and 39 with vaginitis in children. About 25 clinics for syphilis and gonorrhea had special social workers assigned to them.[1] The number of clinics has enormously increased since this study was made. Under the force of war necessity, "the conspiracy of silence" concerning these diseases was largely broken. The Cham-

[1] See "A Great Medical-Social Problem: The Experience of Hospital Social Workers in the Social Problems of Syphilis and Gonorrhea," *The Public Health Nurse*, Vol. X, No. 4, August, 1918, pp. 4–26.

berlin-Kahn Act, passed in 1918, not only provided for an active educational campaign against the so-called "venereal diseases" but also for the establishment of clinics for treatment under special funds paid through state boards of health. Private hospitals and dispensaries have also been stimulated to extend their provision for treatment of persons affected. So very rapid and wholesale an extension of facilities and legislation for the care of those who present such varied and complex problems has not been wholly satisfactory. Public health measures and the welfare of the individual are not synonymous, and since syphilis and gonorrhea are officially recognized to be the concern of public health authorities only while the disease is infectious, we must look to a more far-reaching plan to assure thorough and effective treatment for the individual.[1] The confidence of each affected person must be secured, and instruction in the seriousness of the disease and a spirit of hopefulness as regards ultimate cure be imparted according to his need. Often other members of his family should be examined, and many delicate personal problems arising out of the patient's medical-social condition be carefully dealt with. Obviously social workers for clinics treating syphilis or gonorrhea must be selected with the greatest care.

The following stories will tell, although very inadequately, something of the methods and point of

[1] See Lewis, Ora Mabelle: "Conflicting Ideals of Public Health and Family Welfare," in *The Family*, May, 1921.

view of workers, and of results that are being accomplished for persons infected with syphilis:

A little baby desperately ill with congenital syphilis and past the aid of medicine, was brought by the anxious mother to the clinic where it very soon died. The mother, an apparently healthy woman, gave a history of repeated miscarriages and told the medical-social worker of her distress in not being able to have healthy children. Her husband and his family had felt that the fault was hers. The woman consented to have a blood test which was positive for syphilis. The family physician who had known them for some time, was asked to talk with the husband and to urge him to have an examination and treatment if syphilis was disclosed. The tests showed that he had the disease, and when the family physician explained to him the nature of it, for the first time the man realized that he was responsible for the trail of miseries that he and his wife had suffered. Both were given regular treatment. Two years later the mother became pregnant, received treatment throughout her pregnancy and gave birth to an apparently healthy baby, now a boy eight years old, who has so far shown no signs of congenital syphilis. A second child, now two years old, was born after both father and mother had been discharged from the clinic as probably cured—blood and spinal tests both being negative. The medical-social contacts made early in this case, together with the intelligence and responsiveness of the parents, have turned what seemed for a time a tragedy into an unusually successful family life.

A young girl of sixteen with syphilis in a very infectious stage, came to the dispensary for treatment. She gave a false name and refused at first to answer questions. She acted as though she expected harsh judgment and certainly no sympathetic interest. The infectious nature of her disease and the necessity for treatment were explained. After a time she saw that the interest in her was real and was willing to

give her confidence. The story as revealed by later social investigation was one of a wretched childhood with an unsympathetic mother, early industrial life, small pay, and the development of a friendship with a girl who had a court record and to whose bad influence she had succumbed. The patient was treated and soon ceased to be a danger to others. A social agency interested in girls helped in the plan for giving her a fresh start. She is now making a good record in a private family and being kept under medical supervision.

An intelligent young woman, a widow, came to the clinic with an accidental syphilitic infection on the lip. The medical-social worker found that she was supporting herself, her child, and her mother by candy packing. She was eager to carry out the treatment. A plan was made by which the patient stayed at home and the mother went out to work. So for several weeks this patient was kept under careful supervision until she was no longer infectious.

Another widow, a mother of several children, likewise came to the clinic with an accidental syphilitic lesion on the lip. She, however, was not intelligent nor was she willing to carry out treatment. The social investigation showed that she was alcoholic and that her children were sorely neglected. In this instance the Society for the Prevention of Cruelty to Children took charge of the children. The co-operation of the Board of Health was secured on the ground that this very infectious, careless syphilitic was a menace to public health. She was sent to an almshouse hospital.

Mrs. D., an intelligent, sensitive woman about forty years of age, came to the dispensary because she had severe pains in her ankles, shins, and back. Plates for her feet were secured but gave little relief. The social worker found that the woman, who was a skilled typesetter, had been the main support of the family for eight years. Her husband, crippled with paralysis, was unfit for work. Her boy of fifteen, a promising young fellow, was attending a commercial high school. The care of the husband in addition to her work had proved too

much for her, and the medical-social worker arranged for the husband's temporary transfer to a hospital. While making arrangements for her husband, the worker secured a history of his illness which she reported to the physician. This information considered in conjunction with Mrs. D.'s persistent headaches and pains in her limbs suggested the possibility of specific origin of her difficulties. An X-ray later disclosed syphilitic disease in the bones of the leg. Treatment was immediately started and she soon began to improve.

The doctor considered it best not to tell this patient the underlying cause of her trouble. She was not infectious and so not a danger to others. The husband was carrying the burden of his mistakes. Three years later he died from general paresis in a home for incurables, to which he had been removed. The son, after he had finished school, studied law at night school and passed his examinations for the bar. The mother has been able to maintain a home but has been too tired and discouraged to take all the necessary treatments for herself. The pains have increased and leg ulcers have developed so that she spends a good deal of her time in bed. Her discouragement was due in part to the fact, as was found later, that someone had told her the cause of her husband's illness and suffering. Although she recognizes and admits that she gets much temporary relief from treatment, she has come to feel that it cannot possibly do her any lasting good.

The principle of individualization in medical-social treatment is most important of application to patients with gonorrheal and syphilitic infections. Medical-social workers as a group resent the assumption that all such infections imply immorality on the part of the patient—an assumption followed by routine approach to the question from a moral point of view. Reflecting the atti-

tude of scientific medicine, they also resent the term "venereal disease" as suitable for designation of a group of diseases each one due to distinct infections with no common basis in cause, symptoms, treatment, or control. "Infants with ophthalmia neonatorum, or little girls with vaginitis may have a gonorrheal infection, but one cannot justly accuse such children of having venereal disease. Children with hereditary syphilis, adults with truly accidental extra-genital infections of syphilis (lips, tongue, tonsil or finger), and the man or woman contracting syphilis or gonorrhea through marital relations, with no illicit action on the part of at least one of the parties involved, should not be put in the class of people suffering from a venereal disease, remembering that the term is applied only because of its social cause."[1] As social workers allied to a scientific profession, we ought to be careful not to add to the confusion in the minds of the public by using or countenancing the use of general, inaccurate terms applied to disease.

Gonorrheal infection, whether it is found in the married woman or man, in the unmarried, or in the eyes of a new-born baby, implies the necessity for immediate, persistent treatment of the original patient, and in the interest of preventive medicine the assurance that those who share the infection with him are also under treatment. In one instance, in which the original patient was a boy of

[1] See Smith, Dr. Morton C. and Lewis, Ora Mabelle: "Venereal Disease," *Boston Medical and Surgical Journal*, Vol. CLXXIX, No. 17, October 24, 1918, pp. 525–527.

ten years with gonorrheal urethritis, a home visit by the medical-social worker resulted in the admission of an eight-year-old sister to the hospital for treatment of a serious eye infection and clinic treatment for a three-year-old sister who was found to have a gonorrheal vaginitis. It is quite evident that skilled medical care in the instance of this family must be balanced by equally effective social care. Legislation requiring the reporting of the disease and compulsory treatment during the infectious stages, while valuable as far as it goes, does not suffice.

The right sort of medical-social worker in a clinic may help to create a wholesome, dignified atmosphere there, may establish such friendly relationships with patients that they are led to persist in taking treatment, and may act as an educational influence in supplementing the doctor's instructions. A few clinics for the treatment of men with gonorrheal infections have employed men social workers. One of these has testified that meeting patients at the time when they were most acutely conscious of need for treatment had given him an opportunity for health instruction from which the men rarely failed to get the moral lesson needed. This social worker has accumulated an astonishing amount of evidence of the ignorance of sex education and ideals with which young men are equipped to face the temptations of life.

In one eye and ear hospital which receives babies for treatment of ophthalmia neonatorum the med-

ical-social worker has conceived of her task as embracing the following functions:

(1) To secure as far as possible breast feeding for all babies from their mothers. (Arrangements are made, if possible, for the mothers to come to the hospital to nurse their babies. Failing this, the help of a local public health nurse is secured to keep the mother's breasts active, so that when the baby returns home he need not have the further handicap of being an artificially fed baby.)

(2) To get an accurate history of the child and any evidence of medical neglect of his eyes at birth or previous to his admission to the hospital: this to supplement the doctor's history.

(3) To report to the Commission for the Blind all cases indicating medical neglect and all cases being discharged with scarred cornea.

(4) To persuade all parents of babies with gonorrheal infections to submit to necessary treatment for themselves.

It should be remembered that not all cases of ophthalmia neonatorum are of gonorrheal origin. One authority places the proportion at about 60 per cent. Most physicians advise having the mother examined for gonorrhea, even if the baby's eyes are negative for that disease. A worker of experience, however, counsels great care in telling a mother who has not been aware of it that she has a gonorrheal infection. She reports several cases in which the mother has been so shocked upon learning the cause of the baby's eye condition and of her own

infection that she has lost her breast milk. The doctor's advice should be sought in all such cases.

The medical-social worker in a hospital caring for babies with ophthalmia neonatorum has a unique opportunity to further education and public health measures for the care of the blind and for the prevention of blindness. Each individual case coming to the hospital should be made a means of instructing all who are interested in the patient. By the accumulation of such experience and evidence it is possible to rouse public attention and to promote legislation bearing upon this form of medical neglect. By this same means it is also possible to develop a general program for the prevention of blindness and the suitable education of those unfortunates who must face life with this handicap.

# CHAPTER V

## MEDICAL-SOCIAL PROBLEMS (CONTINUED)

MATERIAL NEEDS. THE UNMARRIED MOTHER. THE CONVALESCENT. CHRONIC DISEASE.

### PATIENTS WITH MATERIAL NEEDS

PATIENTS with very evident material needs are often brought to the attention of hospital social workers. Ragged clothing, obviously insufficient food, inability to pay for orthopedic apparatus, distress over inability to earn the necessary weekly wage are symptomatic of problems which the trained social worker knows cannot be intelligently dealt with by money alone.

The doling out of relief unrelated to a comprehensive plan for the patient is often as unintelligent as giving an anodyne for a headache without considering its cause, or of applying any available salve to a skin eruption without knowing the medical diagnosis. The methods of sound medical service which the hospital social worker sees exemplified each day—examination, diagnosis, and treatment in logical relationship—have in none of her work a more important lesson for her than in these cases where material relief is needed. In social work as in medicine emergencies may occur in which such help must be given, but discrimination

about what constitutes an emergency is a test of wisdom in either profession.

In some social service departments large relief funds are raised and freely drawn upon to furnish food, rent, clothing, apparatus, and vacations. Such departments hold that a patient's medical needs are so likely to be closely related to his physical condition as to be a responsibility of the hospital social worker, and therefore a charge upon the department treasury. Other workers believe that a legitimate service of medical institutions is to provide apparatus such as braces, crutches, and glasses, but they would limit aid to these medical appliances. Still other hospital social workers are convinced that it is not the proper function of the hospital in any of its departments to give material relief.

Possibly the chief danger of distributing material relief as a regular social service function, is the tendency on the part of patients, doctors, and workers, to confuse the main essentials of hospital social service with the relief. Material assistance has a way of overshadowing the less tangible assistance given by workers. The hospital social worker should realize that if a patient needs a pair of shoes he probably needs other things as well, and that these should be given only as part of a plan to make him independent of further aid.

Many social service departments have loan funds by means of which apparatus, such as glasses, braces, and plates, can be procured for those who can pay for them in small, regular

amounts. In one hospital a loan fund of $150 was used many times over during the year. The chief points to consider in regard to loans are, first whether money provided should be a loan or be given outright; second, that if it is a loan the arrangement should be businesslike, and a patient be made to understand that he will be expected to repay according to the agreement. Unpaid loans indicate faulty work on the part of social workers as much as the irresponsibility of patients.

Any hospital social worker of experience knows that many dispensary patients are self-supporting until sickness comes. Their budgets have no margin for such catastrophes. The trained worker must have discriminating judgment to recognize such cases when she finds them and to deal with them accordingly. In a large clinic, where about 400 persons with infantile paralysis and scoliosis were treated and much apparatus was ordered, the social worker gave the following figures for nine months. Orders for apparatus were issued to 260 patients: of these 260, 138, or 53 per cent, were able to pay when the appliance was delivered; 73, or 28 per cent, paid in instalments arranged for by the social worker. The sums thus paid amounted to $456.50. For 28 patients, or 10 per cent, help was procured through interested social agencies to the amount of $479.50; 14 had apparatus paid for out of a special fund; and in 7 instances the patients paid part ($31.50), and the special fund part ($11.95).

The following case illustrates the procedure in one instance: A little two-year-old Italian child, one of the unfortunate victims of the infantile paralysis epidemic in 1916, was a regular attendant at the clinic. In the course of time a brace was ordered for the affected leg for which the father paid. It was known that he was a house painter and he seemed well able to care for his family of five. Later a new socket was ordered for which the mother said she could not pay. It was also noticed that the child's underclothing was not warm enough. On visiting the home the social worker found that the family was not having proper food, that the baby was not well, and that the father's work was intermittent because he too was not well. He complained of having felt increasingly weak for the past year and said that he was under the care of a private physician. His savings were gone. The baby was brought for examination and a formula ordered for which the father could not pay. The Family Welfare Society was asked to help get the family onto its feet. The private doctor was seen, work was secured for the man, but he insisted that it was too hard for him. His funds being exhausted he was sent to the dispensary, where a diagnosis of lead poisoning was made and the muscular weakness thus explained. Several weeks of intermittent aid was needed. The father has now returned to his work after careful instruction as to the necessary precautions to take in handling paint. The paralyzed child meantime must continue for years under supervision, for at ten years of age the orthopedist anticipates an operation to stabilize the foot. Braces will have to be changed every few years as the child grows. The oldest girl, now fourteen years of age, has a special gift for dressmaking and could probably earn a little toward the family support. But the father is very eager that she shall continue in school until she is sixteen. The Family Welfare Society and the hospital social worker will jointly befriend this family, aiming to restore the father to full-time steady work and health, to reduce the child's handicap to the minimum, and to prevent the

lowering of standards which sickness has already seriously threatened.

In another instance, a Pole thirty-five years of age, about to be discharged from a hospital ward, was referred to the hospital social worker as "needing guidance during convalescence. Myocardial insufficiency, cause unknown. Prognosis not good, probably recurrence. Careful adjustment to work important."

This patient, Mr. M., had been employed in a small barber shop by his brother. He had earned $30 a week with tips. He was anxious about the support of his family, consisting of his wife and seven children under thirteen years of age. Seven dollars a week from a lodge was the only income. Fearing a catastrophe and recognizing a problem of long-time family support, the hospital worker asked the Family Welfare Society to plan with this father and husband. Some aid was given in food, clothing, and fuel. The man attempted part-time work but could not stand it. The doctor declared him incapacitated and mother's aid from public funds was granted the family. The patient lived for a year, reporting occasionally to the clinic. During that time the mother received counsel in managing her budget and the selection of suitable food for her growing children. As she was expecting a new baby prenatal care was secured for her, and counsel and help in various family difficulties were given. After the father's death the undertaker, who had sent an exorbitant bill, had to be dealt with. The mother, who was overwhelmed by the loss of her husband and the prospect of her confinement, was befriended. The oldest daughter, now fourteen, was expected by the administrators of the public fund to go to work and assume part of the family support, but as she was not strong and had manifested a heart lesion, a medical statement was secured enabling her, for a while at least, to avoid the stress of industrial life. All this service had been made possible and consistent because it was guided not only

by the medical social worker but also by the Family Welfare secretary.

The division of responsibility for relief between medical-social departments and other social agencies has not been standardized for the whole country. Probably, for some time to come, it must be worked out community by community with reference to local conditions and resources. But everywhere, as in the cases just cited, policies should grow out of recognition of a mutual need and in mutual confidence.

## THE UNMARRIED MOTHER

One of the most appealing problems in hospital social work is that of the young, unmarried girl facing maternity. In a general hospital, in comparison with other groups of patients, the number of such girls is often small, but their great need makes their cases loom up in social service departments as especially suitable for social service.

The dispensary clinic and the maternity ward offer most advantageous approaches to the illegitimate mother. She is usually referred to the social worker just after she has learned that she is pregnant, or when her fears through many anxious weeks have been confirmed. Or the first meeting may come later in the maternity ward, after the baby has been born while the mother has fresh in her mind the mysterious joy as well as the agonies of motherhood. Thus the hospital social worker is able to take advantage of that psychological

moment in the girl's experience which may furnish the best possible access to her real self. The worker can also avail herself of the medical resources for arriving at a judgment of the girl's mentality, if that is in question, and can seek advice and treatment in cases where syphilis or gonorrhea are complicating the pregnancy. All these medical facts and aids which are important to any plan for the welfare of mother and child, are not so readily accessible to an outside social agency which undertakes treatment at a later stage and primarily from the point of view of the social problems involved. These important assets of hospital social workers have led many of them to feel that responsibility for the whole welfare plan should rest with their departments. It is well, however, for the hospital worker to remember that she is not facing an emergency but rather a life problem. In assuming responsibility for the oversight of an unmarried mother, the department must face the necessity not merely of carrying her through the period of confinement, but often of keeping in close touch with her for many years. Its policy in this matter should receive the frankest and most far-sighted consideration, for the medical aspects of the case are usually only temporary. The physical pain that these mothers must endure is often trifling in comparison with the mental suffering that the world metes out to them, no matter how bravely they may face their duties. A sympathetic and helpful friendship must sometimes last out a

lifetime in order adequately to share the mother's struggle.

The medical-social treatment of an unmarried pregnant girl, carried out through the joint counsel of the social service department of a general hospital, a children's protective agency, and the girl's family is reported as follows:

A girl fourteen years old was brought to the out-patient department of the hospital by her maternal aunt, whom she was visiting. A diagnosis of five months pregnancy was made. She claimed to know who was the father of her child and gave the necessary identification, stating that he had been the best man at her sister's wedding one year previous. The girl's statements proved later to be correct.

An old medical history was found that disclosed the fact that, four years earlier, she had been a patient at an eye and ear infirmary where she had been treated for congenital syphilis, probably interstitial keratitis.

The aunt gave the information that the mother had been pregnant when married. The older sister had also been pregnant at the time of her marriage, and an older brother had been committed as a "stubborn child" to a training school for boys. The patient had, so far as the aunt knew, committed no previous sex offenses and had always been a quiet, well-behaved girl, and a great favorite and companion of her father.

A diagnosis of congenital syphilis, together with these facts of the girl's family history and the added fact of her pregnancy, would have discouraged some workers from attempting constructive treatment. But in spite of all this there seemed to be enough material to work with. The aunt was intelligent and anxious to help. The girl was on good terms with her father—a great asset in her re-establishment. The girl herself seemed worth while. No hospital social worker, however, could have handled the case alone. As the girl was a

minor, the man had committed a statutory offense in addition to being liable for illegal paternity. The Society for the Prevention of Cruelty to Children was asked, therefore, to share the responsibility of treatment, and the two agencies worked the case out together—one guiding the medical aspect, one the legal, and the two jointly the social.

The man, who was twice the girl's age, was an ex-service man with political aspirations. He had once been defeated as candidate for mayor in his home town. As soon as the two social agencies started their investigations, he became suspicious and ran away. En route, he wrote a letter to the girl which would have convicted him had other evidence failed. Through the efforts of the Society for the Prevention of Cruelty to Children the man was traced to Florida. He waived rights of extradition and was brought back, under arrest, to face two charges—begetting out of wedlock and statutory rape. The extradition expenses were borne by the town in which the man was prominent and where, at the time of action, he was himself a detective with police power. He was tried and found guilty on both counts. The court ordered him to pay confinement expenses, and he was placed on probation to pay to the court $5.00 a week for the support of the child during its minority. The case against him for statutory offense was placed on file, but remains so only during payment of the money ordered by the Court. Should he at any time fail to pay the weekly sum, the case will be reopened and the alternative of a prison sentence be imposed.

A physical examination of the girl found her to be strong and apparently healthy in spite of the diagnosis of congenital syphilis. She was placed immediately under the care of a prenatal clinic with the joint supervision of the department of syphilis at the general hospital. A mental examination graded her as sixteen years—she had become fifteen years old during her pregnancy.

Before the birth of the child, the girl had remained with her aunt and had come with her aunt and her mother for

medical supervision. She was confined in a lying-in hospital. The question of marriage was raised and looked upon favorably at first by both the girl's father and mother as well as by the girl, but this plan was absolutely discarded after certain discrediting facts concerning the man were unearthed in the course of the investigation.

Three workable plans for the future of the mother and baby were then discussed with the relatives:

1. To place the baby in a supervised boarding home and have the girl go to a small school for girls where she would receive training which her youth seemed to justify and which her mother felt it would be impossible for her to get at home.

2. To have an agency especially equipped to supervise mother and baby, undertake the placing of the mother and baby together.

3. Supervision of the mother and baby in the girl's own home.

The second plan was agreed upon by all concerned up to the day the girl was to be discharged from the hospital. Then her father came forward and insisted upon having the girl at home. Here mother and baby became fully identified with the family life. The child is now a healthy boy of two, to whom his mother's people are devoted. The mother herself is working steadily, and has shown no delinquent tendencies.

At no time during this social treatment was there any duplication of work, any confusion in the minds of the family, or any difficulty in working out the plan. Skilful work was performed by both agencies, each appreciating the function of the other.

As already said, the hospital social worker has a special responsibility in safeguarding the health of an unmarried mother and her baby. Even if the worker expects some social agency in the community to carry the burden of the charge of mother and child, as a medical worker she should urge the

importance of prenatal care, of good obstetrical service, and of the importance of breast feeding. Usually the baby's health as well as his social opportunities are jeopardized.

Many social workers are convinced that the problem of the unmarried mother is not so much one of the illegitimate mother as of her child. Coming into the world without the safeguard of a home, without the protection of a father, and sometimes without that of a mother, he is sorely handicapped. Children's aid societies everywhere are dealing with the illegitimate child with or without the mother. Children's societies in Boston, Philadelphia, and Baltimore, for instance, consider the illegitimate child as their charge. In recognition of this responsibility, the Boston Children's Aid Society has made an arrangement with the social service department at the Boston Dispensary by which unmarried pregnant girls are referred to them, and they undertake the care of both mother and child.

The technique of co-operation in this relationship is of interest. When such girls come to the dispensary they are referred to a special worker. She procures from the doctor a statement of the physical condition and from the girl only enough information for accurate identification—such as addresses and names of some relatives—and for the giving of intelligent advice. Whatever may be secured of "the story" is passed on to the Children's Aid Society. She is given a card of introduc-

tion to the worker and is made to feel that she is being sent to some one sympathetically interested in her. A telephone message is sent to the social worker at the society saying that the girl is to be expected. In especially delicate situations the worker from the Children's Aid Society meets the patient at the dispensary.

By this plan the dispensary makes the medical examination and supervises such medical care and treatment as its physicians deem advisable; the social work is done by the Children's Aid Society. All contacts and transfers of mothers between the two offices are made entirely by two special workers. Reports are sent to the dispensary by the society giving information to date of all patients referred. The following is a sample of the kind of report:

Margaret Lutz[1] took her baby home from the hospital, a boy born October 4. Mrs. Lutz's grandfather was arrested at about the same time, taken to jail, and later removed, after a serious attack of delirium tremens, to a hospital for mental diseases. Mrs. Lutz, who was not at all well, and extremely overwrought by these events, tried to get us to board the child. Not succeeding and expecting her grandfather to be brought home dead any moment, she answered an advertisement and placed the boy at board. Miss Croswell called next day, learned the situation, took Margaret house-hunting so that she could establish the family in a new locality, and persuaded her to board the boy temporarily with the Baby Hospital while the family moved. We made the family a loan for moving expenses and rent, and within a week they left their dingy neighborhood for a pleasant home near the Fells, where they can start over again among strangers. The

[1] All names used in descriptions of cases in this book are fictitious.

grandmother will care for the baby while Margaret goes to work.

While not assuming that the fact of having given birth to an illegitimate child of necessity suggests feeble-mindedness, it is important to recognize the fact that feeble-minded girls have not the safeguards of good judgment and intelligence, and are therefore more susceptible to the influence of unscrupulous men. An early recognition of the mental and moral irresponsibility of an illegitimate mother may save years of painstaking but futile efforts to build up a character that can never stand alone. Custodial care or complete protection from moral danger is the only safe plan for such a girl.

An attractive young girl of twenty was one day brought to the attention of a hospital social worker. Simply and quite unmoved, she discussed the life she had been leading and the future before her. Easily led, lacking in sensitiveness, except when her physical emotion was stirred, she had been the easy prey of degraded men. A few months of observation gave evidence which was accepted as assurance of feeble-mindedness. She could not be judged by the standards nor helped by the methods which apply to the normal girl. Institutional care was procured for her, to the great relief of her family who are caring for the baby. Her ready acceptance of the institutional régime, her contentment with the simple life there, are in keeping with the irresponsibility which characterized her and which was undoubtedly at the root of her troubles.

Institutional life for the feeble-minded girl is clearly the best method of protecting her from the temptations she is sure to meet in the outside world, and society from increase of the mentally

unfit.[1] On the other hand, institutional care for the normal unmarried mother is unsound if it means protecting her against dangers which she must encounter when she returns to community life. Especially is it unwholesome if a highly emotional religious experience is continually stirring in her the overcharged feelings closely akin to those that brought her to disaster. Constructive effort for the unmarried mother must be based on such traits in the girl's character and nature as will help her to withstand the emotional appeal of the temptations she will surely meet. We know too little of the nature of the emotional life, whether it be that of sex or religion, to be sure that the religious appeal will always call forth the sustained strength that will carry an impressionable girl through the hours of trial. Fortunately, some of the "rescue homes" are seeing the truth of this fact and depend more and more upon character forming habits, industrial training, and the careful following of the girls after they leave the institution, while depending less upon sudden conversion through an emotional religious appeal. The hospital social worker before using such homes should know in detail the routine of life and instruction within them. They frequently offer the path of least resistance, for their doors are generously open as a refuge to the girl in despair.

To bring about a permanent resolve and change

[1] See Goddard, Henry: The Kallikak Family. New York, The Macmillan Company, 1912.

in the girl, however, her nature and her background must be studied to find out what there is to build upon; the helpful co-operation of her family, her church, or her friends may be necessary. She must be made to feel the responsibility of motherhood either through the personal care of her baby in some place where she can herself support the child, or by arranging to board it where she can see it often. The human ties of motherhood, of family, of church, must be strengthened through a long period of understanding and friendship, so that she will be led to see what a life of service to others may mean.

The social worker must recognize that the marriage ceremony is no magic by which evil is corrected or moral character constructed. A marriage, unless it is founded on a love that will give some promise of happiness, is hard to justify. None the less, the social worker must feel the obligation that fatherhood should carry, and make an effort to bring a sense of this duty to the illegitimate father as well as to the illegitimate mother. No artificial plan for the life of the helpless infant can modify the physical facts of motherhood or of fatherhood. If there is no marriage it is always wisest to protect by legal procedure, whether in court or through a private lawyer, any arrangement for the support of the child and mother by the father. Most social service departments can procure the services of a lawyer willing to help in the procedure necessary in these cases.

During the past decade considerable progress has been made in better legislation designed to guard the well-being of the illegitimate baby, to deal justly with the mother, and to place the burden of support on the father. The social worker who knows at first hand the injustices and hardships to which mother and baby are subjected should feel a responsibility to promote legislation for their protection. Preventive measures will remove some of the pitfalls that still lie so thick along their pathway.

The point of view of a social worker who must deal with unmarried mothers is important. If she is arbitrary or inelastic she is not suited to her task. Those who have had the most extensive experience with these problems and are wisest in handling them, recognize the complexity of the social, moral, physical, and psychological factors. All are here intertwined; all are deeply rooted in human nature and society.

The worker should have a broad human understanding; should recognize that the girl before her, be she shrinking and frightened or defiant and hardened, is probably swayed by forces within and about her which she does not understand. Much of the social work that has been done in this field has been cloaked in secrecy and sentimentality. Within recent years, thoughtful counsel has been taken among those who have had long experience. The special studies made under the Federal Chil-

dren's Bureau[1] and the various conferences on illegitimacy that have been formed in the United States, give promise of higher standards of social case work with illegitimate mothers, of a more general recognition of the illegitimate father's obligation, and of better legislation to protect the unfortunate child.

At present the hospital social worker has, therefore, not only an important service to render to the unmarried mother at a strategic point in her life, but out of her experience she can contribute to the further study of the subject.

## THE CONVALESCENT

By convalescence we mean here not merely the period of return to normal activity following a surgical operation or an acute disease, but also the gradual restoration to vigor of the patient who is fatigued or debilitated for one reason or another. Hospital social service has been largely responsible for the change in interpretation of convalescence in the past decade. Through this service physicians and hospital administrators have had their attention repeatedly called to patients who are leaving the hospital before they are fit to return to their homes and the responsibilities there awaiting them. They have accumulated evidence of the grievous results of incomplete recovery and of the recurrence of disease because of neglect during the convalescent period. There has also been the more reas-

[1] "Standards of Legal Protection for Children Born Out of Wedlock," U. S. Children's Bureau, Bureau Publication No. 77, 1921.

suring evidence of the results of carefully planned convalescence, of a planning which has contributed to the gradual development of methods of after-treatment for several diseases. Through this experience has come a terminology that is significant. The term convalescent *care* is giving way to convalescent *treatment*, with its deeper implications of a *plan* for restoration to health. Experience has convinced the thoughtful hospital social worker that convalescence to be successful must be the result of a plan both medical and social—a plan that applies not only to a patient's physical condition but to any condition in his environment that should be modified if he is to achieve complete recovery.

When first facing the problem of convalescence, hospital social workers pleaded urgently for more institutional provision. There is unquestioned need of it, but we now know that convalescent homes will not in themselves meet the whole need. It has become clear that routine use of them does not make for success. Many patients for temperamental or social reasons do not do well in an institution.

Since institutions suitable for convalescent treatment are few, it is particularly important that they should be used with discrimination, and that more opportunity for complete recovery should be provided at home, when this is at all possible. This is the way one social worker carried out this principle:

A single woman forty-four years of age was referred with a

diagnosis of "nervous debility" and the urgent request that arrangements be made for her to give up her work, as she was in imperative need of rest. The patient was so emotionally upset that she was incoherent in speech and wept throughout the brief interview with the social worker. So the worker sent her home with the assurance that she would come to see her the next day and talk over plans. The patient was found in a very neat four-room tenement in an uncongested part of the city, living with her old mother whom she supported by giving music lessons. The mother was able to do the simple housework, but she was not strong and the daughter would not consider leaving her alone. Also, if she gave up her work for several months, as the doctor advised, she feared she would not only cut off her source of income but would lose her pupils altogether to another teacher. In discussing the pupils, the fact was disclosed that two of them were particularly difficult.

The only relative was a married sister with a family and few resources, in another state. In consideration of the patient's attitude toward her responsibilities, a tentative plan was arranged, with the doctor's sanction, which the patient agreed to try. A definite daily régime was outlined for her. She was to stay in bed until noon, her bed having been moved into a room where she could lie by a window in the sun. Her diet was carefully stipulated with extra nourishment between meals. She was persuaded to give up the two pupils who were particularly trying. Thus she was able to face each day for the three weeks until Christmas, when she arranged with her pupils that they should have two weeks' vacation. Then she, with her mother, was sent to a convalescent home for the two weeks, where she had every consideration from a matron who understood what those two weeks meant to her. When the patient returned to take up her work again, she kept on with her former régime. Over Washington's Birthday and at Easter she went off again to the country. In the summer, when her pupils were themselves on vacation, it

was arranged to have her go to the country for a long rest and change and her mother was sent to the other daughter. Thus was the patient helped to adapt the doctor's advice to her particular situation and to gain strength while carrying her responsibilities.

Sometimes a patient needs mental hygiene rather than rest in an institution. A woman of twenty-eight, single, with a diagnosis of "debility" was referred for a vacation—"two weeks in the country." She was sent without question to a convalescent home where she demanded considerable attention and insisted upon talking of her symptoms to the other patients. Before the week was over she had left the home disgruntled. The patient's own home was wretched and, on her own urgent request, she was allowed to go to another convalescent home where friends of hers had gone. She stayed two weeks and returned somewhat improved. But she was soon back in her former condition. After the doctor saw her again he advised sending her to a sanatorium for nervous patients. This was arranged. She seemed to improve for a time but was easily involved in disturbances with other patients and finally was discharged by the superintendent as a character problem rather than a neurological one. But the patient's problem was not thus settled, and the hospital social worker, nothing daunted, made another attempt to help her. First, she wrote her a friendly letter which contained the following good advice: "You can get no lasting benefit from anything now except your own attempt to control yourself and what you do, with your mind. It is no use to dwell on what you consider unkindness and injustice. It is only harmful to think of such things. Turn your thoughts to pleasant things. Don't say 'I won't tell people how much I suffer' for even when you say this you are thinking more than you should about your own unhappiness. Don't think I do not appreciate your difficulties and your hardship, for I do. If I did not believe that you were capable of this effort I am urging you to make I should not ask it of

you." Then followed an interesting suggestion for occupational therapy and arrangements for someone to teach the patient to do some weaving at home. This she readily responded to, and her interest was sustained when she saw that she could make something beautiful with her own hands. Thus this patient who could not benefit by institutional life and whose influence was detrimental to the other patients, is being helped by mental hygiene, occupational therapy, an occasional visit to the clinic, and by the steady friendship of the social worker.

One of the chief functions of the social worker seems to be to help the patient to become *free to gain*. Worry over home duties and the apparent necessity to hurry back to work may render the most ideal conditions for recovery practically useless. Helping a patient to overcome obstacles to treatment, in so far as it means readjustment of family life and freedom from responsibility and anxiety, is in large part the social worker's task.

The *definite regimen* that has the authority of the physician and is adapted in its practical details to a patient's situation has proved to be beneficial to such as can be led to follow it day by day during the period while strength is returning. A routine program is often restful to those who have no inclination to use their own initiative at such a time. Social workers who have been observing the convalescent are agreed that the psychological phase of convalescence has not received sufficient attention. The period of physical and often mental depression through which a patient must pass may be made much more endurable by the understanding and

advice of one who can help him through this period and so plan with him as to make him *free to gain.*

In several hospitals it is agreed between the administration, the physicians, and the social worker that patients on leaving the wards must be discharged socially as well as medically. Thus no one is considered physically fit to leave the hospital unless the social service department assures the physician that the convalescent period is provided for. This plan is established at the Children's Hospital of the Boston Dispensary and at the Milwaukee Children's Hospital. Such a scheme assures intelligent planning for a patient's aftercare, and need not necessarily retard discharge. But too often patients are referred to the social service department just about the time that they are to be discharged, thus not allowing time for intelligent planning for their convalescent period. The following story illustrates this point:

A child of seven who had been in the hospital ward for three weeks with pneumonia, was referred at noon "ready for discharge." A social worker in the district was called by telephone and made a hasty call at the patient's home. Both parents were out, but a neighbor said she would look after the child, so she was sent home in the afternoon. The next day the hospital social worker called and found that the mother and father were working and that a nine-year-old brother was staying with the patient who had had no breakfast and seemed very weak. The father proved to be rather irresponsible and the mother had for some time assumed part of the burden of support. A family welfare society was asked to assist in adjusting the family problem so that the mother might stay at home with the children. But the child was in evident need

of special care, so application was made for her admission to a convalescent home. Admission could not be secured for three weeks and by that time she was received with some hesitation because she was so weak. The wastefulness of this too familiar procedure is in sharp contrast with more intelligent *planning* for the convalescent period which we find in some hospitals, where doctors and social workers co-operate more closely in the interest of thorough medical-social treatment.

The attention that has been given to the subject of convalescence has reacted on the convalescent home, and we are seeing a new spirit manifest itself in the management of many of these institutions. The most striking example of a constructive program for convalescence is that of the Winifred Masterson Burke Relief Foundation at White Plains, New York, where medical supervision, occupational therapy, supervised play and exercise, have been merged to build up a comprehensive program for recuperation. Their elaborate scheme is made possible through a generous donor, but many of the principles that are being worked out there are applicable to a smaller institution.

### PATIENTS WITH CHRONIC DISEASES

Chronic disease brings to a person not only a challenge to his character, but problems of support and many adjustments of his way of living and of his desires. The marvelous courage, the cheerful resignation of many patients on whom chronic disease has laid the heaviest restrictions is a source of inspiration to those who have witnessed these triumphs of character. He who has had to face the

fate of physical helplessness is often brought to the point where he asks very little of life except decent care for his body, which he may accept without humiliation, some friendly contacts, and simple occupation to pass the long hours of idleness. It often falls to the hospital social worker to help such an one through the first days and weeks of adjusting his attitude to the prospect of a long and maybe hopeless disease, to the necessity of giving up cherished hopes and plans and normal human relationships. Adjustment of the attitude of family and friends may be even more difficult.

In a hospital for acute diseases, such cases are a problem for the administration, and the social worker is often asked to arrange for their removal in order to free the beds for acute cases. There is the utmost need here to understand the patient's state of mind in order to devise a suitable plan for his after-care. Unaided by social service, many hospitals established for the treatment of acute conditions are obliged to keep chronic cases on for months or years because it seems heartless to discharge them. Or they may send such patients in a more or less routine way to an almshouse hospital. In the performance of such duties, as in all others, the hospital social worker who tends to routine procedure is unfit for her task. She should consider each patient's situation as individual and exercise her resourcefulness to make the best plan possible in co-operation with him and with those who are responsible for him.

Most states offer some form of institutional care for the indigent, the insane, and the tuberculous. Few communities, however, have sufficient institutional care of the right sort for persons with other chronic diseases. The social worker should, of course, know of all such resources and then use them with discretion. Many patients who require nursing care but not constant medical supervision, may be suitably placed at home with the daily attendance of a visiting nurse; while those who are ambulatory may possibly be kept under treatment if they regularly attend a dispensary. When institutional care seems imperative, not only should the medical suitability of a hospital for chronic cases be considered but also its fitness in relation to the patient's character and temperament. In a small chronic hospital one difficult patient may be an upsetting influence to a whole group. Or a crowded almshouse hospital ward may be entirely ill adapted to a patient who may be without financial resources but whose whole background and experience make almshouse associations wholly unsuitable.

Patients who have been placed either for temporary or permanent care in an institution may often be kept there contented if a little human interest in their welfare can be provided through some outside person. The tragedy of a human being lost in a big institution can be appreciated only by one who has experienced it, or by one who is familiar with the eager waiting of lonely sufferers

for a letter or a visitor. When there are relatives or friends, the worker may be able to make them realize what these attentions mean. If the patient is alone in this country, without family or friends, then more than ever will the letter, the paper, the magazine, or best of all the occasional visit, be appreciated. Tender care he may receive from the nurses and attendants but, being human, he will probably especially enjoy the contact with the world outside from which he is cut off.

One hospital social worker made the most of her opportunity for service to a Polish patient who came to her attention when he was admitted to the hospital for study of obscure symptoms that had incapacitated him for several months. Six months previously he had been taken to another hospital in the same city and had been discharged from there to the almshouse hospital, where he remained for two weeks. Since then he had worked intermittently as a baker. After careful study the diagnosis was still uncertain but an exploratory operation was advised. The patient spoke little English, though he understood enough to give the following information: He was forty-four years old, single, and had come to this country six years earlier. He had worked as a baker, had earned good wages, and put aside regular savings in the bank. (His disease had affected his eyesight and he did not know how much he had in the bank. Would the worker please look it up and let him know?) During his illness a brother-in-law in another state had agreed to keep up his payments in a Polish benefit society. Before the operation, which the patient knew might possibly be serious, he wished to make his will. The social worker found that he had about $900 in the savings bank. She secured a lawyer from a legal aid society to come to the hospital and execute the patient's will, and arranged for a Polish priest to see him

before the operation. The operation disclosed a cancer of the kidney and the doctors reported a hopeless prognosis. The patient, not realizing his condition, wished to go to a nephew in St. Louis. The doctor, when informed of this, told the patient the truth about his condition and advised transfer to a private hospital for chronic cases where he could have nursing care for the rest of his life. It was then the task of the social worker to persuade the patient to let her arrange for his care in the private hospital and to draw on his savings to pay the $10 a week board required. She arranged for the patient's transfer, wrote to relatives about the seriousness of his condition, and passed on to the superintendent of the chronic hospital such information as was important for her to know. The worker kept in touch with the patient for the four months that he lived, sending occasional reports to his relatives. Arrangements were made for the Sisters from a neighboring Polish church to come frequently and sing Polish hymns with the patient, much to his delight and to that of the other patients. The superintendent of the hospital reported to the social worker that the patient knew that his end was near, but that "he was perfectly ready to go. He had no worries as his affairs were all arranged and he was content, since he could have proper care and the comforts of his religion."

Unhappily, chronic disease does not usually affect the patient alone. The hospital social worker is familiar with the tragedy of the broken family—broken because the mother of little children is stricken or the father of a dependent family is rendered helpless. Even if suitable care can be secured, the patient will not benefit by it if he is worried about unfulfilled responsibilities.

Chronic disease sometimes presents a more difficult problem with those who are ambulatory and able to lead a partially normal life. In the case of

patients confined to a hospital bed or on a rigid dietary in a ward, restriction of activities and control of appetites may be less difficult to achieve than in the case of those who are semi-invalided. The dominant problem of the ambulatory patient with chronic disease is usually that of keeping up his courage in order that he may persist in the regimen prescribed, live within his physical limitations, and preserve or develop his sense of responsibility in carrying his share of the treatment, and, more difficult still, in finding life worth while.

The method of group or class treatment, which was originally devised by Dr. Joseph H. Pratt,[1] in the therapy of tuberculosis, has been very generally applied to other chronic diseases. With heart disease, diabetes, infantile paralysis, scoliosis, and nutrition cases this method has been used very successfully. In all of these ailments the patient has a definite part in the program. The weekly group meetings with the doctor and social worker or home visitor; the opportunity to share with others in a friendly way experience which has previously seemed difficult to accept; commendation for following instructions or censure for failing to do so; the encouragement to greater effort—all of these help to make treatment effective or at least worth while. One social worker in charge of such a class comments thus: "The group treatment helps to develop a loyalty and co-operation which

[1] See Pratt, J. H., M.D.: "Principles of Class Treatment and their Application to Various Chronic Diseases," *Hospital Social Service*, Vol. VI, No. 6, December, 1922, p. 401.

bring patients back to the clinic and make them more ready to follow advice. It also gives a sense of comradeship which is of great value. The habit of doing things that are hard or monotonous is much more easily acquired when others are also doing them. New patients soon lose their shyness; those consumed with self-pity seldom fail to find others making less of greater handicaps; and the discouraged man or woman hears how someone else gained when conditions seemed quite as hopeless."

The social worker's part in the group treatment of cases of heart disease, for instance, is not alone to keep patients coming to the class but to overcome, with each patient, any obstacles to attendance at it, to see that the schooling of the children is not interfered with more than is imperative, and that advice and practical assistance are given adults in the selection of an occupation, pursued for either economic or therapeutic reasons.

That the treatment of chronic disease has been distinctly promoted by the assistance of hospital social service departments is without question. The future holds further opportunities for them to contribute to the study of chronic disease in its social incidence and cost, in its loss of working capacity and its frustration of satisfactory living. Careful social case work may thus not only serve the patient but also contribute to medical-social research.

# CHAPTER VI

## MEDICAL-SOCIAL PROBLEMS (CONCLUDED)

MENTAL DISEASE AND DEFECT. THE PHYSICALLY HANDICAPPED.

### THE TREATMENT OF MENTAL DISEASE AND DEFECT

IN tracing the history of psychiatric social work in this country, we find, as has been indicated, the beginnings of such work in the New York State Charities Aid Association's after-care of patients discharged from hospitals for the insane. The purpose of this service was to help the patient and his family in his adjustment to community life, and to supervise him for a period of parole from the state hospital.

A closer interrelation of social work and psychiatry was developed under the guidance of Dr. James J. Putnam, then Chief of Neurological Service at the Massachusetts General Hospital, and vitally interested in the newly established social service department there. Dr. Putnam maintained that:

> The physician [in a dispensary] is apt to touch the real lives of his patients as at the circumference of a large wheel; the social service worker can often penetrate more deeply and may open avenues which the physician can then follow and on which he may go still further.

These are services which are useful in every kind of illness, but particularly useful in the case of patients with certain disorders of the nervous system. For these patients are often great sufferers from troubles which they cannot at once or easily reveal, and indeed do not clearly understand. Their fears, prejudices, and misapprehensions take on numberless forms and are often rooted in traditions and experiences which only long and intimate contact with persons of sympathetic and thoroughly understanding minds can bring to light and counteract. Such patients need moral air and sunlight and new outlets for activity and thought as much as the tubercular patients need the physical air and sunlight through which they gain new holds on life.[1]

Dr. Putnam secured as his assistant in 1906 Edith N. Burleigh, a social worker of training, experience, and insight, to whom he gave special instruction. Together they developed and applied the principles of the interrelation of medicine and social work in the understanding and treatment of mental disease.

Margherita Ryther, Miss Burleigh's successor as social worker for the Neurological Clinic at the Massachusetts General Hospital, formulated her service to the clinic as falling under the following main groups:

1. *Social investigation before making plans for disposition and treatment;* such as arrangements for institutional care in hospitals for mental diseases, schools for the feeble-minded, epileptic colonies, state or city infirmary or almshouse, or for supervision in the home.

[1] Third Annual Report, Social Service Department, Massachusetts General Hospital, 1908, pp. 57–58.

II. *Social investigation as a contribution to diagnosis.* Mild and incipient mental disease usually manifests itself in behavior that varies from the patient's normal. Changes in temperament and attitude modify social relationships. In cases where the physician has reason to suspect a mental disease but cannot make a diagnosis on the evidence to be obtained in the clinic, he looks to the social worker to secure discriminating reports from the social laboratory—the home, the workshop, and the school.

III. *Social study to supplement physicians' treatment,* an analysis of the patient's environmental conditions, hereditary influences, and temperamental tendencies. This study is particularly applicable to the psychoneurotic patient who must be treated largely outside institutions and through processes of re-education.

To quote Miss Ryther's own statement:

> The physicians in the clinic have not the time to study the causal social conditions contributing to the nervous invalidism of these patients, and the information secured is of value to them in rounding out their clinical examinations and making it possible to advise the best treatment. . . . It is just here that the social worker in the clinic is useful, since by getting from the patient the needed data she saves the physician much time and the foundation is laid for good medical and social team-work, which is of decidedly greater value to the patient than either alone.
>
> He is made to see himself and his environmental conditions from an objective point of view. He learns to understand himself and his relation to others; he is enabled to re-

view his life's development; he is made to face his faulty traits of character and unfortunate inherited tendencies. He sees not only his weak but also his good qualities, and through this increasing knowledge and release from former self-ignorance the means and opportunity to re-establish himself is provided. This breaking down of old habits, false beliefs, etc., cannot be accomplished at once. Self-knowledge is only the first step toward gaining emotional poise, but the light thrown upon the patient's life through the unraveling of his social background is the foundation of ultimate recovery. Through the social study the patient is awakened to his responsibilities to himself and others. His confidence in the worker and doctor being established, he is started upon a course of mental hygiene consisting sometimes of months of patient reiteration of the need for daily practice of healthful habits. The social worker continues to assist with the patient's treatment through interviews and home visits and gradually becomes the bond between the patient and the doctor. Furthermore, she follows the case between visits to the hospital and is thus able to have ready for the physician at each visit of the patient much information of value to him in his conduct of the case.[1]

The following story illustrates how the social worker may help to make the treatment plan possible:

Max, a Hebrew boy of eleven years, was brought to a dispensary because he was "very nervous." The father said that the child had tried several times to jump out of the window, that he laughed and cried uncontrollably, and that he had had trouble with his teacher. During his examination the child was very incoherent—said that his hair was on fire, that he was on the "dangerous list"—talked in snatches about moving pictures and about his troubles with his teacher,

[1] Ryther, Margherita: "Neurological Social Service, Massachusetts General Hospital," *Boston Medical and Surgical Journal*, Vol. CLXX, No. 12, March 19, 1914, pp. 408–411.

who, he said, had told him he "never could get well." A diagnosis of acute mania was made. After persuading the father to sign commitment papers, the social worker accompanied Max and his father to the psychopathic ward of a hospital, where the boy was placed under careful supervision. His symptoms continued to be more and more violent, and at the end of a week he was transferred to a hospital for mental diseases. Meanwhile the social worker had seen home, teacher, and family physician. The teacher showed great interest in the boy. She had been troubled about his condition and had often been at a loss to know how to manage him. She said he had called her vile names. She had reported this fact to the master of the school, who made Max apologize. Otherwise there had been no trouble between them. She supposed that he was not properly controlled at home. She said also that the patient had been confused in his ideas; for instance, after a talk on hygiene in which sulphonaphthol was suggested as an antiseptic for cuts got while in bathing, he insisted on using sulphonaphthol as a hand lotion until his hands were sore.

The visit to the boy's home showed the family to be living in a fairly comfortable tenement, although the building was dark, dirty, and in a crowded district. The parents seemed well-meaning but had not good control of their children. Nothing in the family history showed a tendency to mental disturbances. As Max had been a newsboy and member of the newsboys' club, the head of the club was seen and the report was confirmed that the boy had been acting queerly lately. He had recently come to the club and said that his father had set him on fire and that he was covered with blisters. He was reported as running wild on the streets, going constantly to moving picture shows, and being erratic about getting his papers. He used to forget to go for them, although he was sent with money to buy them.

The little fellow was kept in the hospital for three months. When he was well enough to leave, the doctors urged most

watchful after-care. As the home conditions were unfit hygienically, and the parents overindulgent, they were urged to pay for the child's board in the country until they could move to better quarters. Through a children's agency the boy was placed in a private home under supervision, where he remained four months. Meanwhile the family moved into the suburbs. They learned, too, that indulgence was not the greatest kindness to their children. When Max recovered, he returned to a home in which much better conditions had been established, and for a year reported every two months to the doctor.

A woman, an immigrant, was one day rushed to a hospital after an unsuccessful attempt to commit suicide in a detention house at a steamship landing. The day after her admission to the hospital she made another attempt to end her life, and four days later still another. The doctors declared her insane and therefore unfit to land in this country. The hospital social worker (who became interested in her) found that she was a Russian and the mother of three children. She finally secured an interpreter who could speak her language. The patient was frantic over what had been done with her children. Investigation revealed the following facts:

The husband had come to this country a year before and had secured work in Michigan. He had sent for his family—wife and three little children—but had not sent the amount of money required by the authorities to allow them to land. The immigration officials had detained the mother and children until the husband could be communicated with. When the money came and the officer from the steamship company went to arrange for their transfer, it was found that all the children had measles. They were hurried to a contagion hospital. The mother, not understanding this proceeding, became excited. People in the detention house told her that the children had been taken away and would be kept in this country and that she would be killed or sent back to Russia. Confused, in a strange country, not understanding the lan-

guage, unable to explain to herself why her husband had not met her, and panic-stricken at the loss of her children, this outraged mother made a frantic effort to end her life.

The hospital social worker became convinced that the woman's actions might be reasonably explained. She got the consent of the superintendent of the hospital to retain the patient until every possible effort had been made to prove that she was not insane. The co-operation of the steamship company was secured. They telegraphed to a representative in Michigan, who agreed to send the husband on at once. The children, now fully recovered, were brought to the hospital by the Russian interpreter, who explained carefully to the mother that as soon as she was well she and the children could join her husband. The children were placed temporarily by a children's agency. On the husband's arrival a conference was held with him, the doctor from the immigration bureau, the steamship official, and the hospital social worker, and the following plan was devised: The children were to be brought to see the mother regularly; the husband was to see her daily; and, if in a week's time she showed no further symptoms of insanity, she was to be allowed to land (officially!) and go to Michigan with her husband and children. This family has been happily united.

Since 1912 there has been a very rapid development of what we now term "psychiatric social work." This name and much of the clarity in thinking and in presentation of principles of the interrelations of psychiatry and social work are due to the vision and pioneer efforts of the late Dr. E. E. Southard, of Boston, and his colleague, Mary C. Jarrett. When organizing the Boston Psychopathic Hospital, Dr. Southard conceived of a social service department as essential to the hospital's performance of its function. In the architect's

plans, space was assigned to this department. The chief of social service became a recognized member of the staff. Dr. Southard and Miss Jarrett did much to systematize ideas on this subject, to encourage training for psychiatric social workers, and also to disseminate practical knowledge of the methods and principles of psychiatry among social workers in general.[1] Signal work has also been done at special clinics organized by the Committee on Mental Hygiene of the New York State Charities Aid Association and at the Henry Phipps Psychiatric Clinic in Baltimore. During the war the interest in mental disease was tremendously stimulated, and the special hospitals for soldiers with mental diseases accepted the psychiatric social worker as a necessary part of their equipment.

These are some of the chief influences that have resulted in a general recognition of the fact that social elements necessarily permeate psychiatry and that social work, in turn, has much to learn from the best that psychiatry has to offer. While psychiatric social work has had a marked influence on the more definitely medical social work, it has reached beyond the hospital to courts, to recreation centers, to industry, and even the school.[2]

A new point of attack upon the problem of the

[1] Jarrett, Mary C.: "The Psychiatric Thread Running Through All Social Case Work," pp. 587–593, Proceedings of National Conference of Social Work for 1919, at Atlantic City.

[2] The history of psychiatric social work and its methods may be found in The Kingdom of Evils, by the late Dr. E. E. Southard and Mary C. Jarrett, The Macmillan Company, 1922.

feeble-minded has come with the greater extension of hospital social service. The hospital social worker has an opportunity to get in touch with these patients as they are brought to the hospital or dispensary for diagnosis as to their mental condition, or are discovered through admission for other diseases.

Mary Acker, a woman of forty, single, was referred to a medical-social worker for immediate institutional care on account of a severe gonorrheal infection. When the worker suggested the almshouse hospital as the only place where the patient could be cared for, Mary poured forth the story of earlier experiences at this same almshouse, where she had several years before given birth to a child. With very little questioning she also told of her good friends at a school where she had spent many years. These friends were well known to the social worker as members of the staff at the state school for the feeble-minded.

Investigation through relatives, the school for the feeble-minded, and hospital records showed that Mary had had a "shock when she was three years of age and had neither walked nor talked until she was eleven"; that she had always been considered below par mentally, and that she had had two illegitimate children; also that she had been for twelve years in the school for the feeble-minded. While there, she had so far improved that her mother had taken her home. After carefully supervising Mary for three years, the mother died. For the next three years Mary had led an irresponsible and immoral life in spite of the desperate attempts of her brothers to restrain her. Their most eager co-operation was offered to secure her readmission to the school for the feeble-minded. Through the superintendent and the superintendent of the almshouse hospital, arrangements were finally made for the direct transfer of the patient to the school as soon as she was free from infection. The report reads: "Patient went hap-

pily to ————, where, after a few days, she dropped into her old place again very nicely." Three months later, the social worker visited her at the institution and found her very happy in caring for some of the young children to whom she was devoted.

Such morally irresponsible women, "high-grade" feeble-minded beings, become social problems, because their weakness makes them a temptation and a prey to ignorant or unscrupulous men, and through them illegitimacy and disease increase beyond our ability to measure. The harmless idiot or "low grade" imbecile, on the other hand, may need institutional care only when it is a matter of humane protection. There are many of these "perpetual babies" who are most tenderly cared for at home. It is well for social workers to realize that with the overcrowded condition of most of our schools for the feeble-minded, it is often not so necessary to urge institutional care for the idiot as it is for the higher grades of feeble-minded persons. But this care and training should be secured as early as possible.

Dr. Walter E. Fernald has declared that "the keynote of a practical program for the management of mental defectiveness is to be found in the fact, which seems to have been proved, that those defectives whose defects are recognized while they are young children, and who receive proper care and training during their childhood, are, as a rule, not especially troublesome after they have been safely guided through the period of early adoles-

cence."[1] That many of them, when well trained in some useful occupation and to be cleanly in habits, can return from the institution to supervision in their homes and to useful industrial life, has been amply proved. In the absence of institutional care, however, the social worker must make sure that the patient has a supervision no less kindly and steady than is provided in our schools for the feeble-minded.[2]

One of the distinct functions of the medical-social worker in relation to mentally defective children is to see that all physical defects are corrected. A physician frequently pronounces a child below par mentally and urges eye or ear examination, removal of tonsils and adenoids, or general hygienic treatment. It then becomes the task of the worker to see that such children receive the necessary medical attention on the chance that their subnormal mental development may be due to remediable physical defects.

The skilled hospital social worker, by the accumulation of pertinent information, such as facts on heredity, school records, psychological traits and actions as seen by the family and others closely associated with the patient, can often bring to the physician data which, considered in conjunction

[1] Fernald, Dr. Walter E.: "A State Program for the Care of the Mentally Defective," *Mental Hygiene*, Vol. III, No. 4, October, 1919, p. 569.

[2] Fernald, Dr. Walter E.: "After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-Five Years," *Ungraded*, Vol. V, November, 1919.

with the mental examination, will help both in diagnosis and in making the best plan for treatment. She may also be able to explain to parents, teacher, or social worker the curious actions of the feeble-minded child—his lack of concentration or consistent ambition, his love of praise but lack of persistence in effort, his inability to compete with normal children, his irresponsibility. Thus harsh judgments may be avoided and plans formulated on the basis of a better understanding. It is easy to love a feeble-minded child, but not so easy to comprehend his simple mental processes.

Dr. Fernald sums up the proper program for the care of the feeble-minded as including "the mental examination of backward school children; the mental clinic; the traveling clinic; the special class; directed training of individual defectives in country schools; instruction of parents of defective children; after-care of special-class pupils; special training of teachers in normal schools; census and registration of the feeble-minded; extra-institutional supervision of all uncared-for defectives in the community;[1] selection of the defectives who most need segregation for institutional care; increased institutional facilities; parole for suitable institutionally trained adult defectives; permanent segregation for those who need segregation; mental examinations of persons accused of crime and of all inmates of penal institutions; and

[1] No estimate has yet been made of the cost of effective supervision of the feeble-minded in the community, and no standards for such supervision have been established.

long-continued segregation of defective delinquents in special institutions."[1] Such a comprehensive program is not as yet in operation in any state, but it is entirely possible and practical, although its success would be dependent on the co-operation of all who touch this complex problem from whatever angle. Hospital social workers, whether or not they are associated with a mental clinic, ought to know the facilities for defectives in the state in which they are working, and should be guided by the experience of those who have gained wisdom in this subject.

## THE PHYSICALLY HANDICAPPED

This classification is a crude one, and is used here only because the medical institution offers one of the most strategic positions for establishing a helpful and wholesome attitude toward patients who, from a physiological point of view, can be so classified. Doctors and hospital social workers frequently come in touch with persons who, because of serious injury, amputation of limb, damaged heart, paralysis, defective hearing or eyesight, seek medical treatment. Furthermore, at the time of their need of medical service they are likely to be spiritually depressed and especially susceptible to the attitude of those about them. It is important, therefore, that the hospital social worker whose

[1] Fernald, Dr. Walter E.: "A State Program for the Care of the Mentally Defective," *Mental Hygiene*, Vol. III, No. 4, October, 1919, pp. 573–574.

business it is to think in terms of the patient's future, should herself realize what he needs.

Any supposition that economic dependence is a necessary corollary to a crippled physique is readily dispelled by such accumulation of evidence as is assembled in the survey of cripples in Cleveland.[1] The triumph of spirit of many courageous men and women over what seems to most of us overwhelming physical handicap gives a basis for the conviction expressed in the Cleveland report that "it is what is *left* and not what is gone that counts" and that "the man behind the handicap" is the chief thing to consider. People may be borne down more by self pity than by physical defect. Such pity is too often fostered by indulgent friends and relations in an ill-advised attempt to make up to the cripple for his misfortune. In face of the evidence presented by many who have suffered physical injury, it would seem that the only insuperable handicap is disintegration of character.

In 1908 the Charity Organization Society of New York established a Bureau for the Handicapped, the function of which was to find jobs for those who, because of physical disability, were not served by other employment agencies. Social service departments in New York hospitals referred many patients to this bureau. It was discontinued in 1912, having yielded the evidence that merely to

[1] Wright, Lucy and Hamburger, Amy M.: "Education and Occupations of Cripples, Juvenile and Adult." A survey of all the cripples of Cleveland, Ohio, in 1916. Red Cross Institute for Crippled and Disabled Men, Publication Series H, No. 3, October, 1918.

find a job that was suitable to a given handicap did not solve the patient's problem.

In 1911, in Boston, the King's Chapel Committee for the Handicapped was formed, and the secretary, Grace S. Harper, given headquarters at the Social Service Department of the Massachusetts General Hospital. To her were referred all physically handicapped patients coming to the attention of the doctors and social workers. As a matter of routine, those having amputations were also referred to her. This made it possible for her to talk over future plans while patients were still in the ward, and thus to forestall the influence of those friends and relatives who so often picture to them a future of dependence or beggary. An instance of such help was that given to a young Italian with double amputation of his legs who, while convalescing, disclosed his ambition to become a tailor. Investigation indicated that he had capacity for this trade, and while he was still in the ward his lessons in tailoring were started through the kindness of a neighborhood tailor. When he left the hospital it was with two artificial limbs—paid for in part by his family and in part by the committee—and with an opportunity, moreover, to enter a tailor shop as an apprentice.

The following instance shows that there are other elements besides physical conditions which may lead to incapacity:

A German, aged forty-six, was brought to the attention of the department because his funds were nearly exhausted and

he was "in need of light work." He had an infectious disease of the joints that left him slightly lame and with hands somewhat crippled. He had not had steady work since the development of this disease, some six or seven years before. Inquiry revealed the fact that he had been a valued employe in a Young Men's Christian Association, where he had proved himself efficient and "honorable" in the capacity of attendant at the gymnasium. Both he and his wife had been employed there for several years. In 1910 she had become insane and had been placed in an institution. A lodge and a German society had aided from time to time, in 1911 sending the husband back to Germany where they expected him to remain. In a few months, however, he became restless and returned to America. The societies again aided and attempted repeatedly to procure light work for him. When positions were found he failed to keep them.

At the time the patient was brought to the attention of the Committee for the Handicapped he was pronounced by the physicians as physically fit for work that would not necessitate heavy lifting. The patient, having expressed a desire for janitor's work and also a wish to leave the city, was given an opportunity to take a position in New Hampshire. After some hesitation he promised to go on a definite train and try the work. When the date arrived he came to say that he thought he would not go to New Hampshire, as he had heard of a possible job as superintendent of a club house where he might be in charge of the repairs, the cleaning, and the bowling alleys. Anyway, "maybe he might not be able to do the work in New Hampshire."

Several other attempts were made to place this patient, but at last, at his own suggestion, he went to the almshouse. Here was a man who had at one time been ambitious and energetic, but through prolonged idleness and semi-invalidism had lost the habit of application.

The handicapped person almost invariably presents during his period of adjustment mental traits

more or less like those of an invalid. Whether these traits are due to the shock of the disease or accident, or to his family's prolonged petting of him, or to the out-of-work habit he has acquired, is a question. Successful work with the handicapped seems possible only when each patient is considered individually and careful attention is given to the traits and tendencies discovered. It becomes a task, not only of finding suitable work, but also of facing with each a process of re-education.

George ——, a boy of sixteen, was referred to the Committee for the Handicapped in June, 1912, by the principal of a school for crippled children. She stated: "The boy's mother is going to live near Concord, New Hampshire, and it seems best for George to leave Boston when school closes and get employment near her." At the age of twelve George had suffered from infantile paralysis. His legs were now in irons and he used two crutches. The principal of the school reported, "he possesses application, perseverance, and willingness; character not very strong; loves appreciation; is kind-hearted and frank, honest and truthful." The instructor in printing reported that George did very well, for the time spent, at typesetting. "He can set straight copy and would improve with practice; has not much imagination when reading handwriting if it is scribbled the way so much manuscript is. He could feed a hand-press easily by leaning against the shelf in front—many people lean on the shelf anyway. He has endurance and strength for seated work, but must have room for his legs to extend straight out when at the bench. He can also manage very well on a stool at the typesetting case."

Miss Harper talked with the boy and found him bright and eager to get a start. He was advised to wear long trousers which would conceal the irons, thus making him less conspicuous. His plan was to visit uncles in New Hampshire

after school had closed, and to be in readiness to respond to a call from Miss Harper at any time. Miss Harper told him he would probably not hear for a week or ten days. In the meantime, he should look around and see what he could find for himself. (This was to let him realize the difficulty in securing work.)

After much inquiry a letter came from a printer in New Hampshire saying, "A keen, ambitious boy is just the kind we are looking for,—one who cares for something more than six o'clock and pay day." They thought he might be useful in the label department if he could sit on a stool and feed press, or stand a little—enough to make corrections and changes in the forms. They would first want to see and talk with the boy, however, and would be glad of more information about his condition.

George had made several applications for work, but without success. When word came that an opportunity was open to him, he was duly appreciative. He was personally conducted to the town, his boarding place arranged for, and the employer seen. When the time came for the worker to depart, George's courage was fast leaving and he inquired about the returning trains. He was persuaded to stick it out, however, and by heroic effort on his part and continued interest on the part of the worker, he stuck to it for a month. At the end of that time he asked permission to return to the city to attend a ball game. When he appeared he was reminded of the employer's first letter, stating that he wanted a boy who cared more for work than for play. He went back with a new determination to remember that he was now a man and must make good. Late reports show that he is doing so.

As a result of her study of the training and placement of persons with physical defects, Miss Harper formulated some suggestions for workers engaged in this field. She maintained that the patient's problem was a psychological as well as a physical and

economic one. For those who are advising them in questions of employment she offered the following classification of the handicapped:

(a) Those able to work under ordinary conditions and without special training.

(b) Those able to work under ordinary conditions if trained for selected trades or processes within trades.

(c) Those physically unfit for the long hours and hard conditions of competitive industry but able to work under special conditions, i. e., a special workshop for cripples.

(d) Those who are incapacitated for work other than occupation for its therapeutic value.[1]

If a social service department undertakes to assist patients physically handicapped, attention to the above groupings will forestall many discouragements and much wasted effort. A hospital is surely not a suitable place for a permanent employment agency, but in communities that have no facilities for serving those in need of special consideration, the hospital social worker may be able to help individuals who come to her attention.

Often patients who must still have long continued medical care should receive from the social service department thought and attention as to their other needs. For instance:

A little girl who, in her second year, was paralyzed by infantile paralysis in both legs and in several of her trunk muscles, was kept persistently under care until, at the age of six, she could wear braces and get around, although with some difficulty, on crutches. The school principal was seen and

[1] See "Special Report of the Board of Education Relative to Training for Injured Persons," Massachusetts House Document, No. 1773, February, 1917, p. 23.

arrangements made for her to be brought to the school each day in a cart. The boy who had the honor of being monitor of the eighth grade was permitted to carry her upstairs to her room. She was saved the further handicap of lack of an education, which was the lot of another child who was found in the same infantile paralysis clinic and who, up to the age of fourteen years, had never attended school. The father of this child, who had himself been brought up in an orphan asylum, refused to allow his child to be sent to a special institution for crippled children. No alternative plan had been suggested, and eight precious years had been largely wasted. A little ingenuity on the part of a hospital social worker might have resulted in an earlier educational opportunity for this ambitious child.

The war not only stimulated interest in mental disease, as already noted, but also gave a new impetus to workmen's compensation legislation, and to vocational education and industrial opportunities for the physically handicapped. The further expansion of legislation under the Industrial Rehabilitation Act (1920) extends the privilege of vocational training in many states to civilian cripples. Such beneficent legislation should have the wide support of medical-social workers, for it cannot function unless it is tested out constantly in terms of its successful application to the lives of those for whom it was enacted.

## CHAPTER VII

## BASIS OF TREATMENT

HOSPITAL social service must depend for its justification, not on the wave of popular interest which it has aroused, not on the gratitude of patients for kindly help, but rather on the effectiveness of the social work that is done. Human kindness alone cannot solve tangled social problems; nor can it minister, unaided, to the body or the mind diseased. As I see it, the social worker's function does not lie especially in a sympathy with patients in immediate distress of mind and body. Physician and nurse often have a deep sympathy with the various phases of their condition. Rather does the social worker's function lie in an enlarged understanding of any psychic or social conditions which may cause the patient distress of mind and body. Character, human relationships, and community life are the fields of her study and effort. Her knowledge of the way in which temperament, financial circumstances, and environment affect a patient for good or ill, added to the doctor's knowledge of physical conditions, gives a sound basis for judgment and for action both medical and social. To make her contribution valuable the medical-social worker must bring to

her task the best that the profession of social work has to offer. While animated by a keen sympathy with suffering, she, no less than doctor and nurse, is in search of truth. But her field is different, and *the value of her contribution depends on the very fact of its being drawn from another field.*

Several factors determine the quality and scope of social work in a medical institution. The skill of the worker, the fruits of knowledge and personality, and the kind of co-operation that she has been able to establish with the doctors and hospital authorities are of prime importance. Other determining conditions are the size of the staff of workers in proportion to the number of patients and the supply of helpful community resources. Of utmost consequence is the willing co-operation of the patient himself. This must be more than mere responsiveness, although responsiveness marks the first step toward a co-operative relationship.

A person usually has a trusting confidence in the ability of the hospital to relieve his physical distress, else he would not seek its help. He is responsive to any one who approaches him on the basis of his physical need. The hospital social worker has, then, the great advantage of an easy approach to the patient and an opportunity for a frank discussion of those social problems that relate to his physical condition. Both patient and social worker tacitly recognize his physical difficulties as the final factors in putting him out of joint with his environment. He appeals to the hos-

pital for medical help, conscious of no personal responsibility for his social condition. As a result, he suffers none of that loss of self-respect involved in asking material aid. When any one applies to a relief society, although more fundamental causes may lie behind the obvious need, the basis on which the applicant approaches the society is usually that of a failure in self-support. While one who asks free admittance to a hospital may feel his failure in not being able to pay for medical attention, his sensitiveness is usually due to belief that he would receive better care if he paid for it. His need of medical assistance carries with it little of the sense of personal failure that accompanies his request for material assistance.

At present physical illness is looked upon as one of the inevitable experiences common to all of us. When we realize, as we may some day, that sickness is the usual attendant of ignorance, neglect, or immorality, either on the part of the individual or of the community, our point of view may change and we may cease to be so complacent about our diseases. The time may come when tuberculosis, infant mortality, industrial accidents, diseases of occupation, many forms of blindness, and diseases resulting from fatigue will be found in our hospitals only to our shame. For the present the patient comes as a victim, not of poverty, stupidity, or vice, but merely of the "ills that flesh is heir to." On this basis he meets physician, nurse, and social worker, and his natural responsiveness is of incal-

culable aid to them. To physician and nurse his relationship is largely one of dependence. But the social worker, chiefly concerned as she is with his convalescence, must help him to help himself whenever that is possible. His cheerful obedience to his medical advisers must be developed into a spirit of active participation in plans for his benefit, if the social worker is to build constructively on the foundation of the medical aid extended.

Medicine no longer depends upon drugs as the chief specific for disease. But few are now recognized as essential in medical treatment. Exclusive of surgical procedure, by far the largest factor in medical treatment is the patient himself; and wherever his co-operation is needed in the preconvalescent stages, the insight into his background which the social worker can supply and the influence that she can bring to bear may become the main agency in assuring that co-operation.

In tuberculosis, heart diseases, diabetes, arteriosclerosis, digestive diseases, debility and innumerable other diseases, treatment, while directed by the physician, calls also for the co-operation of the patient. He himself must often change his habits of living or his way of thinking, sometimes even definitely change his environment. This makes medical treatment a joint partnership between doctor and patient. The social worker comes in here as an interpreter, and sometimes as the active agent in making the patient's part possible and effective.

To help to establish this co-operative relation the social worker should have all the factors in the case well in hand. She should have first of all an intelligent appreciation of the patient's physical condition, not merely the name of his malady. This is always an important first step in understanding his needs, as well as her basis for common action with the doctor. Next, it is her responsibility to see how far that physical condition is complicated by elements other than those which the doctor can detect by his professional methods.

In her search for these elements, which form the background of the patient's difficulties, the hospital social worker must consider not only his physical state as presented by the doctor, but also his mental and emotional condition, and his social status as she can deduce them from the various sources of information open to her. Her interpretation of his physical state should include the doctor's diagnosis, and especially his prognosis and plan of treatment. Although the medical record is open to her, the medical-social worker depends far more on the doctor's interpretation of the record as he discusses the case with her. Most medical records, particularly in dispensary practice, are so meager that one should procure additional facts from the physician as soon as possible. In some hospitals, the Boston Children's Hospital, for instance, the social worker makes rounds with the visiting physician and thus has an opportunity to report upon the social conditions found at a time

when the physician still has the patient clearly in mind.

A physician's plan of treatment is sometimes modified in the light of the social conditions disclosed. Take the case of a debilitated girl working in a factory: the doctor has prescribed rest, variety of food, and outdoor life; but it may seem wiser, on knowing the facts, to develop a plan of treatment based on a better observance of the laws of hygiene, or a change of occupation, because any attempt to give her a radical change of environment could be only temporary. Thus, the social worker must at times be willing to accept a second best plan for her patient, but she must not lose sight of the fact that it *is* second best when considered from the physical side alone.

The psychological elements which the social worker must consider are of fundamental importance. To those who know people in physical distress it is a commonplace that the psychological may in so far color the physical condition as to make the same disease in two individuals seem due to different infections. This is equally true of economic conditions. Poverty may take the vitality out of one man, may find another philosophically acquiescent, and spur still another to renewed efforts. Prosperity produces a similar variety of results.

In the interplay of the physical, economic, and psychological elements, the psychological dominates; hence understanding of the subtle reaction

of human nature to circumstance should engage the most thoughtful efforts of the medical-social worker. In this reaction the experience of psychiatry is of immeasurable importance and one of the great contributions to social case work method during the past decade. To secure a knowledge of a person's character involves piecing together facts from many sources: from his looks, manners, dress, and bearing; from what he says; from the attitude of his mind toward the difficulties of life; from all that can be learned about the time of "his high-water mark" in the social world; and from his own hope or despair as to the future. His personal and family history with its indications of the influences physical and mental that have helped to determine his present condition are essential to understanding him. A knowledge of all these factors is often of much more importance to the plan for the patient's future than that of his previous economic condition. The worker's understanding of these aspects of character depends on her power to see meaning in the facts which she collects through the conventional methods of history taking.

The first talk with a patient may disclose few social facts. The skilled medical-social worker has no difficulty in taking this first step. The patient readily understands the worker's function, because his need of her is closely related to his immediate physical disability. The only essential element in the first interview may be to secure the patient's confidence, to establish a friendly relationship, and

to explain to him her own function as related to that of doctor and nurse. In our work with nervous patients or girls in moral danger this is particularly true. In their eagerness to get at social facts, social workers sometimes expect to enjoy the confidence of the patient before it has been gained.

But a certain outline of information must be obtained: a patient's age, his residence, nationality, part in the family group, occupation, and something of his economic situation. These can be ascertained through direct questions; they give a background for further details and sometimes offer clues to the causes of his difficulties. I recall a man sent to a social service department in order to ascertain the source of his lead poisoning. He had given his occupation as shoemaking. The social worker noticed a peculiar habitual movement of his mouth. Following this clue, she discovered that for several years he had held in his mouth while at work the little metal pegs used in his trade and had thus absorbed the poison into his system.

After securing the first necessary facts, the social worker should ask few leading questions; rather she should have the patient tell his story as fully as his time and her own allow, guiding him sometimes and selecting from his disclosures those facts which bear particularly on the social aspect of the case. The art of a first interview includes questioning and listening with a plan in mind, but with a perpetual readiness to change that plan. Direct questions are likely to bring out only the state-

ments the worker is looking for and may leave hidden some of those unexpected sources of anxiety that are the real source of trouble.

A woman sent by a doctor to a hospital social worker to secure her medicine free, was found on investigation to be struggling under a burden too heavy for her to bear. Since she and her three children had been deserted three years before, she had supported them by day's work. A son was desperately ill with appendicitis at the city hospital. Another child, concerning whom the mother was greatly worried, had incipient tuberculosis. Had the hospital merely provided the tonic which the doctor ordered for this mother, and given no consideration to her anxieties for her children, it would have profited her little.

If a patient's social problem is uncomplicated, a superficial knowledge of facts may be all that is needed. It is impossible, however, to tell beforehand how far the search must go. When Lincoln Steffens began to investigate the shame of the cities in a certain state, he soon found that he must follow the trail to the state capital and ultimately to Washington itself. With the doctor's diagnosis and plan of medical treatment at hand, one must realize that the aim of the social investigation has not been attained until an effective plan of medical-social treatment can be formulated to meet the needs of the patient. Again, it takes as much discrimination to know when the inquiry should end as when to go on with it. The only sure way to test any decision based on slight information is to follow up the case and see whether the result has been what the worker anticipated. If a girl has

flat-foot, but is otherwise in good health and able by an easily arranged plan to pay for her plates, further action on the part of the social worker may not be justified. Additional understanding of the patient, however, may indicate the necessity for her changing her work to one less trying to the feet. From the comparatively fortunate state of this girl there are all gradations to the desperate condition of the unfortunate drug habitué for whom nothing can be done, either medically or socially, because with our present limitations no amount of social knowledge, investigation, or work can make treatment effective.

Investigation of the social side of a person's life is tabooed by many who do not understand its motives or value. Often doctors themselves are impatient of it. Some people even regard the questioning of a patient as an impertinence. But impertinence implies a base motive. If doctor or hospital social worker has a plan in view for the good of a patient into which his answers to questions fit as a piece into a picture puzzle, there is no possibility of impertinence. The social worker must be ready to explain to herself or to the patient the reason for each question. There can then be no misunderstanding on either side. During her inquiry, facts of character come out on both sides. The hospital social worker who has learned something of the art of dealing with people will never allow her questions to become stereotyped. They

will be related closely to the need which seems at the time to be urgent.

A visit to the patient's home is often essential to a better understanding of his social status and living conditions. It also serves to illuminate his trouble from his family's point of view, which is sometimes much saner and usually somewhat different from his. To carry out an effectual plan usually requires the family's help, and at times it is greatly modified in the light of a home visit. The following case illustrates the value of learning home conditions:

A nervous little girl of fifteen was once referred by a neurologist to a social service department with the request that she be sent to a class for stammerers. A teacher of articulation had told the neurologist that he would gladly take some patients in his Saturday afternoon class. Realizing the social and economic handicap of her affliction, the girl stammered out her appreciation of this opportunity, which was all the better because it would not interfere with her working time. A talk with her and a visit to her home revealed the fact that this anemic, nervous girl was working nine hours a day in a net and twine factory, where her fingers were flying every moment; that daily she walked a mile to her work and a mile back; and that at the end of the day she returned to cold rooms and to entirely inadequate food, improperly prepared. The mother, a prematurely old widow with two daughters, worked all day in a factory, though she was entirely unfit for it, and had no strength after her work to attend to the physical needs of her family. Their total income was wholly inadequate. Through the efforts of the social service department, a church, and a family agency it was made possible for the girl to go away for several months' rest. After a year of watchful oversight the social worker

succeeded in bringing her to the condition where she was fit to have the training in speech.

A person's family is usually more ready to co-operate when the trouble is physical than when it is economic. The thought of pain and possible death rouses a sympathy which is keener and quicker in its action than that produced by the thought of poverty and unemployment. A worker should make the most of this psychological situation both to secure the information necessary for understanding the patient's circumstances and to interest the family in the success of the plan for his treatment.

If the patient has a suggestion of his own, that should be considered first even if it is an impossible one, for he is more likely to give his co-operation to a modification of his own idea than to an entirely new one. In fact, the final plan must be a composite adjustment of three points of view—those of doctor, social worker, and patient.

Patience and tactful persistence are often necessary to bring about the adjustment of these three points of view.

A young man came to a dispensary for treatment of enlarged glands in his neck. On examination it was found that these glands were tubercular and that there was an incipient tuberculosis of the lungs. Immediate sanatorium care was advised by the physician, and the hospital social worker was asked to make the necessary arrangements for his admission. The young man and his family had a dread of hospitals which the worker could not overcome. Failing his going to one, she kept watch of him at home, instructing him in hygiene and

urging him from time to time to accept sanatorium care. After a few weeks an abscess developed in the glands of his neck. He then consented to enter a general hospital for a few days to have the abscess treated. This experience dispelled his fear of institutions, and he consented to go to the tuberculosis sanatorium immediately after his discharge from the general hospital. Thus the original plan, although belated, was carried out, with the most sincere gratitude of the patient and a realization of his former misjudgment.

In many cases the interview at the hospital and one home visit suffice to secure needed information. Success is marked by ability to formulate an effective plan of treatment without further study. By the time investigation has gone as far as the possibility of a plan the worker should begin to see which personal tie the patient regards most tenderly and what influence can be strengthened to help solve his present difficulty. These aids may be found in the family, the church, the employer, the fraternal society, or a friend—in fact, in any of the natural ties.

The sources of information about any patient then are varied, and can be completely utilized only by a social worker who knows how to follow clues and to discriminate between those that are important and those that are not. Many a bulky social record has missed essential points.

Tentative social treatment based only on superficial study is sometimes necessary in view of the urgency of a patient's condition. In medical work the patient with a hemorrhage is treated immediately to stop the bleeding before further exami-

nation is attempted. It is recognized, however, that hemorrhage is a symptom and not a disease. Behind the hemorrhage may be tuberculosis of the lungs, an internal injury, or some other grave disorder. Just so an emergency outfit of clothing is the treatment of a symptom only. Patients who need material aid almost invariably require more than that, and the hospital social worker should not be content with emergency social service except in the very rare cases where none other is required. A sick person in need of material things is peculiarly appealing. A grocery order, like a dose of morphine, may ease present distress. But the medical-social worker must remember that mere relief can rarely prevent a recurrence of the real trouble. The cause should be the object of her search, for not until it is known can any intelligent plan be developed.

Social investigation, like medical examination, may be either simple or involved, local or systemic. The surgeon who is called upon to treat a broken arm does not first take the patient's family history before setting the bone. If there is no further indication of difficulties, the bone is set and the patient departs. If he presents obscure symptoms the diagnosis may have to be deferred until, by X-rays, laboratory tests, or a period of observation the true condition is revealed. While minor symptoms may have immediate attention, any comprehensive plan of treatment must be delayed until the physician has determined the diagnosis. In the same way

the skilled social worker must be able to discern whether the patient is deeply or only slightly involved in social difficulties before she can know how extensive to make her examination or what plan of treatment to follow.

I remember a woman sent to a social service department by the admitting physician of the dispensary. He had admitted her later than the hospital rules prescribe because she had told him her delay was caused by her walking from her home. The physician asked that carfare to and from the hospital be given her during the time she needed treatment for some local disease. The social worker had a talk with the patient and visited the home where a friend also was seen. Here she discovered that the family was in no financial need, as the husband was earning enough to provide for his wife and children. The woman stated that she had been "very nervous for several years," a story which her friend corroborated. She was eager to talk of her symptoms and troubles, and finally it came out that she had a "phobia" about riding in street cars and had not been in one for several years, not even on the day after the superintendent had given her her carfare. Thus was disclosed a mental condition far more serious than her local trouble and more difficult to cure. To give her carfare was aiming wide of the mark.

Mere surmises or guesses must not be construed as facts. The latter can be had only after intelligent search, by balancing sources of information, and by a critical attitude toward prejudiced statements. Many things are likely to blind us in our search for the facts in social inquiry. First, the lack of experience on which to base sound judgment. Second, our own emotional response. We are inclined to inject our own feelings into a judg-

ment of the patient's distress of mind, and to formulate an opinion without getting a true perception of his condition, for the sick person's point of view is often warped, as also may be that of his family. That is one reason why he should have the social worker as an adviser. If she is to do her greatest service she must keep her judgment balanced and sane.

A young boy of sixteen was more in need of the social worker than he realized. His legs had become quite helpless through an attack of poliomyelitis that had not been skilfully treated. The best the doctors could do for him, when he came to the attention of a well-known dispensary, was to prescribe braces, so that he could walk with crutches. Two or three years of sickness and idleness and an indulgent family had left him with little ambition. The social worker had not only to teach the boy patiently and persistently to keep at the job she procured for him, but also to strengthen the morale of his family so as to prevent them from giving him entire support. She taught both patient and family that happiness was to be found in work, not in idleness, and that the best protection for this boy was an ability to care for himself.

Failure to take into account all the important psychological elements involved in such a situation as the above would make social treatment ineffective. Thus, only after seeking for the many-sided truth—whether illness and maladjustment are matters of finance, hygiene, psychology, or past conditions—can a sound plan of action be developed. Often the truth when found reveals little promise for effective effort. Many a social worker has spent months or years of fruitless struggle at

reconstruction of character, only to find that the boy or girl was feeble of mind and consequently incapable of self-control. If this fact had been known earlier much energy, unjust criticism, and disappointment might have been saved.

In discussing the aim of the medical-social worker's investigation, Dr. Cabot once said to the writer: "Patient and worker can rest content when—and only when—they have done *either* what is efficient *or* what proves that efficiency is here and now impossible. Miserable uncertainty and fruitless effort are the worst of the miseries confronting harassed social worker and struggling patient. Next to being cured there is a very genuine satisfaction in knowing that one must endure to place one's fate and find a foothold *somewhere*, even in defeat. Definiteness—after exhaustive study—is the one thing all patients can rightly demand and all workers rest upon. It is no mean support. I have seen its benefit to many. It sets worker and patient free to think clearly about something or someone else."

# CHAPTER VIII

## WORKING TOGETHER

THE number of social agencies in a community is not in itself a true measure of its social resourcefulness. The more or less haphazard development and the unrelatedness of these various agencies in our cities is gradually giving way to an intelligent recognition of the necessity for thoughtful consideration before any new ones are organized. There must be complete readiness to work together on the part of those responsible for the use of funds provided for social welfare in its various forms. The community survey[1] gives a reasonable method for studying both the social needs not yet met and the adequacy of the existing welfare agencies.

The hospital has heretofore been one of the most isolated of the social institutions. Hospital social service was instituted, in part, to correct the weakness of that isolation and to recognize the general principle of the relatedness of all phases of man's social life.

The hospital social worker should consider her-

[1] See, for example, Harrison, Shelby M.: Social Conditions in an American City, A Summary of the Findings of the Springfield Survey. New York, Russell Sage Foundation, 1920.

self morally responsible to foster the conscious interrelation of the hospital and the other social agencies in the community from which patients come.[1]

The social worker must know what the resources of the city are and how to use them judiciously. She can no more afford to be ignorant of the agencies that may be called upon than a doctor can afford to be ignorant of the remedies used in the treatment of disease. They are her social pharmacopia. Nor must she be too dependent upon any one remedy as a cure-all; there are quacks in the treatment of social disorders as there are in medicine. The diet order, the orphan asylum, and the convalescent home offer examples of remedies often used that are not always adequate. The test of skill is a worker's ability to realize fully the social conditions of a patient, to prescribe the social elements in treatment intelligently, and to find the means to carry out effectively the social treatment required. The tired girl may not only need a week in a convalescent home; she may need to be taught how to sleep and to eat, how to get proper amusement, or to adjust herself to circumstances in her home that cannot be changed but may have seemed intolerable.

The well-trained social worker will recognize expert service where it has developed within the various agencies, and out of a sense of justice to the

[1] See Byington, Margaret F.: "What Social Workers Should Know about Their Own Communities." New York, Russell Sage Foundation, 1919.

patient as well as to the supporting public, will seek it for those who may profit by it. For instance, the children's agencies, experts in placing and supervising children in foster homes, are asked by hospital workers to apply their skill on behalf of sick children whose own homes are inadequate to give them proper care during convalescence. Should, however, a community contain no such expert service, the trained hospital social worker must be able through her own knowledge to apply the principles which should guide the placing of children in foster homes. She should know to what national authorities she can turn for advice. She will be careful, moreover, to avoid the needless multiplication of these agencies in carrying out the treatment of any given case. Other things being equal, the fewer the number of workers dealing with one patient the better. It should be the aim to keep the program of treatment for each patient as simple as possible without endangering his welfare.

Sometimes a worker in prescribing social treatment must depend on changing the environment. Sometimes the remedy must be compounded out of the forces within the patient himself. Still another patient may need the aid of a specialized agency in the community or of several of them. The social worker must then construct a plan that combines these resources. Or, for instance, where a father is having difficulty in keeping his boy in school while the mother is in the hospital, she may

see fit to enlist the interest of school teacher, truant officer, and clergyman in her attempt to relieve his anxiety. In such circumstances she must have the kind of skill shown by the physician whose carefully balanced prescription combines several drugs in proportions that are much more helpful than any single one of them.

The hospital social worker is peculiarly placed to understand and encourage co-operation. She hopes to see the hospital become a more consciously social institution than it is at present, but neither she nor any enthusiastic promoter of the service wishes to have it lose its characteristic function as a technical institution for the physical care of the sick. It cannot and should not so enlarge its scope as to be able to meet all the social needs of those whose physical well-being it seeks to promote. She cannot build up within the hospital a well-organized family welfare society, a factory inspection department, or a department of school nursing. Recognizing this, we should not attempt to multiply special activities within the hospital itself without first studying existing social resources and the extent to which it would be reasonable and practicable to utilize them.

Each new social function of a hospital should, I believe, have passed the challenge of two questions: Does not some agency already exist that could serve the patients as well or better than this new department? Can that agency be induced to extend its function to cover this particular prob-

lem? For instance, one hospital social worker, finding several children with chronic disease in the hospital and desiring to have them taught for a few hours each day so that they could keep up some of their school studies, secured the interest of the board of education to put a special teacher in the hospital ward as an extension of the public school system. Another hospital social worker suggested that the public library establish a branch in the hospital, and this was done to the great benefit and pleasure of patients.

While the conviction in the minds of many that the social difficulties of hospital patients are unique is soon dispelled by a real understanding of the problems encountered by other agencies, nevertheless there is no other place at which so many of the complications in the lives of human beings converge. Fatigue, moral danger, family instability, legal complications, drug habits, and incurable disease are some of the evils that beset mankind irrespective of economic conditions. That a patient's need for social service is not synonymous with his financial stress has been amply proved. The great majority of persons with medical-social difficulties, however, especially those whose needs are most dire, belong to the same group of people who come to the attention of other social agencies. While the hospital population represents a great variety of economic levels, it would seem that the large bulk of people frequenting our charitable hospitals are victims of the many forms of social

difficulty with which family welfare societies, visiting nurses, and settlements have long struggled.

The experience of social workers in hospitals in which patients pay part or all of their expenses has amply proved that many of the evils which press hardest on people without financial resources are not unfamiliar to those of higher economic status. No thorough survey of the industrial, social, and financial standing of hospital patients has ever been made. Among them, no doubt, are some whose sickness is the result of wretched social conditions; others whose disease may prove to be the road by which they will become social dependents; and others still who by a narrow margin will again become self-supporting when they recover.

A step toward an enlightening analysis of persons coming to a charitable dispensary was taken in the winter of 1911–12 at the Boston Dispensary. The study covered only 116 patients—the total number of "new" applicants at the hospital on two days. It is, however, valuable, first because it proves that hospitals offer an opportunity for social service to people on a variety of economic levels, and because it exemplifies a method for determining roughly the financial standing of those who seek free dispensary treatment. Among the 116 patients, investigators found the following economic conditions, classified according to the groups defined in Booth's Life and Labor of the People of London:

| | | |
|---|---|---|
| Casual laborers | 8 | |
| Unskilled labor, low paid, irregular work | 21 | |
| Unskilled labor, low paid, regular work | 36 | |
| Total unskilled and casual labor | | 65 |
| Skilled labor, irregular work | 13 | |
| Skilled labor, regular work | 19 | |
| Total of skilled labor | | 32 |
| Clerical work | 9 | |
| Business (managers or owners) | 6 | |
| Professional occupation | 1 | |
| Total of clerical and higher grades | | 16 |
| Total | | 113 |
| Patients living in an institution | | 2 |
| Information insufficient for grading | | 1 |
| Grand total | | 116 |

Thus, 56 per cent of the patients are in the grades of unskilled labor or below; 28 per cent in the class of skilled labor; and 14 per cent in clerical or business groups.

It would be an error to draw from these percentages any direct inference as to the proportion of patients who could have paid a private physician. Eligibility for dispensary treatment cannot safely be determined from economic grade alone. The members of the family of a clerk with six children, earning $18 a week, may be much more suitable subjects for "medical charity" than an unmarried laborer earning $12.[1]

It will be seen that to meet the needs of the individuals within these various groups the hospital

[1] Davis, Michael M., Jr.: "Efficiency Tests of Out-patient Work," *Boston Medical and Surgical Journal*, Vol. CLXVI, No. 25, June 20, 1912, p. 917. These wages would be higher, of course, if Mr. Davis were writing in 1923.

social worker must be resourceful and imaginative, ready to grasp her opportunity to adapt social service to many people with many kinds of needs.

A catalogue of the city's resources is an invaluable assistance. Many cities have directories of social agencies in which they are grouped according to their function, with indexes, cross-references, and annotations to suggest the means of approach, such as the names of the executive officer and office hours. The city directory, which in the larger cities has a wealth of information concerning churches, lodges, and business organizations, and the yearbooks of various religious denominations and separate churches are also helpful. Many state boards of charities publish the names of those charities incorporated by the state. Of the smaller towns and cities few have any published list of their charitable resources, and a worker is largely dependent on the accumulation of her knowledge for accurate information about such agencies. But unless she has a seasoned experience and technical skill in weaving these various resources into her process of investigation and social treatment the bare list of them will be of little avail.

A simple method of compiling information about a community's resources is to make a card index of such as do not appear in any published directory. Such data can be carefully classified according to subject and location so that it may be readily accessible for use. An index of this character should be assembled as need of it becomes evident, and

may contain the names of lodges and benefit societies, their officers and addresses; people interested in certain nationalities—for instance, Poles, Italians, Swedes; special information on church clubs, charities, and funds. Social service departments have found it of value to procure names of firms and notes of prices for the outfits of tubercular patients; of carpenters who will build outdoor sleeping porches; of reliable boarding houses with notes about accommodations and prices; of lawyers, doctors, and interpreters who will volunteer their services, or of individuals who would give time and personal interest to patients needing friendly oversight and long-continued supervision. Such a catalogue is especially valuable to social workers whose field covers not only the city in which their own hospital is situated, but which extends into outlying towns and cities. In the Social Service Department at the Massachusetts General Hospital a list of some 2,000 resources in the cities, towns, and rural communities outside of Boston has been collected and gradually arranged in card catalogue form. The case number of a patient helped by any one of the agencies or persons tabulated is often entered on the card, so that reference to the case record will give more details about the quality of help secured. As frequent changes take place, it has been found necessary to assign to one person the task of keeping this catalogue up to date.

One very helpful feature of such a compilation

is its presentation in convenient form of data about other hospitals. Much effort is saved by consulting the cards in obtaining detailed information about the hospital resources of the city, both private and public, the types of cases accepted, the scale of charges, and the method of application for admission. Cross-reference cards indexing the special groups of cases accepted, as cancer, chronic diseases, and tuberculosis, are also useful.

Both public and private agencies are to be found in most cities. The public agencies represent the responsibilities which the community has already undertaken to support and administer. The obligations first recognized by the state are for the protection of its citizens through prisons, hospitals for mental diseases, almshouses, and so on. A gradually enlarging sense of civic responsibility constantly increases the number and variety of public agencies. Most cities have a charitable and correctional group of such institutions which deal with the economically dependent and with those whose conditions, moral or physical, are a menace to the community. Even the court may be a resource to a hospital worker in cases in which an unmarried mother is looking to the hospital for help, or where a worker seeks to protect a criminally neglected child. Among the city and state agencies most used by a hospital social worker are other hospitals, almshouses, institutions for the care of mental diseases, the epileptic and feeble-minded, sanatoria for the tuberculous,

city ambulances, overseers of the poor, boards of health, tenement house and factory inspectors, school teachers, physicians, public health nurses, and any other persons or means that may be invoked to help the sick in their homes.

Among the private agencies with which the hospital social worker should be familiar are those dealing with family problems—such as family welfare societies and Jewish and other specialized societies; children's agencies, both those that place children in foster homes and those that supervise the child in his own home, such as the baby welfare societies; societies for the protection of children from cruelty; visiting nurses, school and industrial nurses, teachers, settlements, churches, lodges, and benefit societies; the Red Cross where it is active in civilian service; and the many religious organizations, such as the Society of St. Vincent de Paul and the King's Daughters.

Every community has a number, if not all, of these agencies. To know where they are situated, something of the quality of their service, and how to work with them are among the hospital social worker's first obligations. In a large city it is very difficult to bring all the complex social agencies into friendly team work. The best way to cut out duplication of effort and to achieve quick, efficient service in the interest of the patient is found in the social service exchange. Such a bureau has been established in several cities. The oldest is that maintained by the Family Welfare

Society in Boston. More than two hundred local social agencies use this exchange. Its machinery is simple and effective. The names and addresses of all persons inquired about are arranged in a card catalogue, with a note stating what society or individual is interested in that particular person or family. Thus this exchange serves not as a bureau of detailed information concerning any individual, but rather as an index to persons who are under the care of one or another of the social agencies in the city. When inquiry is made by telephone or mail the file is consulted. If the name of the person asked about is already known to any agency, the inquirer is told *that fact alone.* Any information concerning the person must be secured through the agency or individual already interested. The social service exchange itself has no other items than those necessary for identification. If there has been no previous inquiry, the identifying information and the name of the agency or individual inquiring are filed in the catalogue. The card is not consulted unless some new agency becomes interested in the family or individual.

The success of such a bureau depends upon three conditions: intelligent, businesslike management of the bureau; strict sense of the confidential nature of all information; and intelligent and prompt use of data secured by the inquirer. Despite careful management a bureau may be rendered useless if inquirers do not follow the clues

given them and so fail to get into touch with other persons or societies who may at the time be actively interested in the same patient as themselves.

The following illustration shows the value of the social service exchange:

A patient came to the out-patient department of a hospital for the dressing of an acute abscess. The surgeon reported to the social service department that he understood she could not return for daily dressings as he had ordered. She was a Hebrew and spoke almost no English. The social worker, after getting the names and address of the patient and her husband, immediately telephoned to the social service exchange and found that the family had been known to several social agencies for many years. The state had charge of two children, a children's agency had charge of an infant that was about to be returned home, and a Hebrew society had for some time known the family. It was the baby's return that was worrying the mother, as she could not carry him to the dispensary when she came for her dressings. The father was anxious to care for his family, but lack of work had forced him to seek assistance. A conference of those actually interested in the family was called. The hospital social worker reported the physical needs of the woman. The children's agency decided to keep the child until the mother was fit to care for it. The Hebrew society renewed their relations with the family and secured work for the man, while the medical-social worker continued supervision of the patient until she was well.

This solution of a complicated family situation by the intelligent co-operation of three agencies took very little of the hospital social worker's time and was satisfactory to all concerned. A second case illustrates the waste of effort due to absence of registration:

The parents of a very troublesome feeble-minded child were loath to send him to an institution. After much effort on the part of the hospital social worker they were persuaded to apply for the child's admission to a school for the feeble-minded. After the application went in, the social service department was informed by the institution that another application had been filed previously by a children's agency. On consulting this agency it was found that the same struggle had been necessary on an earlier occasion to persuade the parents of the wisdom of custodial care. The parents had come to the hospital in the hope that an operation could be performed which would cure the child and make institutional care unnecessary.

A contrast is shown in the following illustration:

A woman came to a hospital in urgent need of immediate operation. She refused to enter because she did not know what would become of her children. On inquiry at the exchange it was discovered that the family was known to the Family Welfare Society. The hospital worker telephoned the society's volunteer visitor, who had known the family for a long time. She immediately visited the family and made a plan with the husband for the care of the children during the wife's absence. Thus relieved of her anxiety the woman entered the hospital. The hospital social worker kept the volunteer visitor informed of the woman's condition. The visitor persuaded her to continue her convalescence until she was in fit condition to resume her family cares.

To those who have used the social service exchange for many years it becomes an expression of true co-operation. It not only says, "Let us know if anyone is already interested in this patient," but it also says, "I am interested in this patient and stand ready to help." Through the operation of the exchange social workers in a com-

munity are continually reminded of one another's existence. Where no exchange exists, a more conscious effort is often necessary to keep a worker mindful of the fact that others are possibly engaged in like problems. Exchange of experience is not only enlightening, it may be highly stimulating. Hospital social workers especially ought to keep these outside relations active, for under intensive pressure and the constant presence of emergent situations there is very real danger of their succumbing to an institutionalized attitude.

A helpful use of community resources is seen in the cases of persons whose physical and social need is so involved as to call for the most skilful co-operation between medical and social agencies. The following example of hearty working together by a social service department, a dispensary physician, a consul, an immigrant aid society, a committee for homeless men, and the patient himself illustrates better than any declaration of principle the value and effectiveness of a cordial and satisfactory working together.

Tony Milano, a bright-faced Italian boy of twenty, wandered into a dispensary one day in June. He complained that he was losing his eyesight and that he was out of work because of that. This was the first time he had consulted an oculist. The doctor found on examination a detached retina in the right eye and a probable beginning detachment in the left. The prognosis was unfavorable. Tony needed daily observation in the clinic. As he had no relatives in this country to whom he might go while he was having treatment a position was created for him at the dispensary where he watched the

doctors' automobiles. This kept him in the open air and made it possible for him to see the doctor every day. He received careful treatment, to which his eyes responded very well, the vision in the left eye becoming almost normal. The ultimate prognosis, however, was unfavorable, and it was deemed best to send Tony back to Italy. There his family had a market garden where he could work out of doors.

Tony readily agreed to this plan although he did not know how he could get back. Also he was troubled because he had not responded to a call for military duty and feared that he might on his return be arrested and forced into service. As Tony was not fit to serve his country, even if his spirit had been willing, the consul was consulted. He gave Tony a large legal document asking for examination by military authorities in Italy, with a recommendation for clemency and hospital care if necessary. He also cabled the circumstances to Naples so that there could be no misunderstanding. Free transportation was furnished through the interest of the Italian Immigrant Aid Society. The agent of a committee dealing with homeless men was interested in Tony and secured for him proper clothes and the necessary money for the trip. A detailed medical account of the case was written to be presented to the physician in Italy, also a letter to the father, outlining the care that Tony should have to protect and preserve his eyesight. These letters were rendered into Italian by the immigrant society. When the day came for sailing, the social worker put Tony on board and interested the ship's physician in him. Six weeks later a letter came from Tony saying that while he missed his American friends and "the customs of our country" he was happy and contented and under the physician's care.

Honest differences of opinion or of methods among social workers sometimes lead to critical judgments and misunderstandings on both sides which may be destructive of valuable co-operative

effort. If, however, social workers have faith in one another's motives, these differences may be wholesome elements in their relations. The fine spirit of frank criticism that has existed in many cities between medical and other social workers has made it possible for them to attain gradually a real understanding of one another and to exchange valuable experiences and special knowledge. Justifying one's point of view and testing one's theories in the light of friendly criticism may be made a process of growth.

## MEDICAL ADVICE TO SOCIAL AGENCIES

As non-medical social workers dealing with individuals in distress have become increasingly conscious of the significance of physical conditions, they have more and more sought the advice and aid of physicians and hospitals. Information as to the physical state of a client is found to be an important element in the formulation of almost every plan for aid. As the mere report of a diagnosis has often little value to a non-medical mind and the prognosis is usually lacking, social workers outside of hospitals have welcomed the worker in a medical-social department as an interpreter.

Many such departments now feel the importance of their service as interpreters between agencies dealing with the social aspects of a case and the medical institution to which the patient has been sent for advice on the physical side. Through one social service department many children who have

come to the juvenile court are sent to a dispensary for physical and mental examination before the judge decides what action he will take in regard to their misdemeanor. In another instance, agencies dealing with children, and those concerned especially with family problems, make a practice of having a physical examination whenever the need of this is indicated. Several social service departments have printed blanks[1] for the "steering" of these cases. These blanks are placed in the hands of the social agencies which frequently send patients for medical examination and advice. The hospital social worker is thus gradually interpreting to social workers outside, the kind of medical facts that it is necessary for them to know.

Mr. Mann, single, forty years of age, was sent by a town authority to a dispensary through a social service department with request for a report on his physical condition. Mr. Mann presented a note saying that he had been a resident of ———— for many years; that he was intemperate; that he had from time to time been an inmate of the town almshouse; and that at present he was destitute. He now complained of pain in his back. The doctor in the clinic found him suffering from an "old Pott's disease." The report as given by the doctor and interpreted to the town agent was somewhat as follows:

Diagnosis, Pott's disease (tuberculosis of the spine); back needs proper support. (1) *No treatment* will result in increased pain and contracted chest and the possible development of tuberculosis of lungs. (2) A plaster jacket which would cost about $3.00 would give relief from pain but prohibit work, and probably mean almshouse care. (3) A

[1] See Appendix, pp. 224–226.

leather jacket would cost about $15, would relieve pain, and make it possible for the patient to work, although he will probably never be well.

The leather jacket was later ordered and paid for by the town.

The following case shows how patients sent for physical examination often need to return for treatment; also that the medical-social worker in the dispensary and the social agency outside can work together to carry out the treatment prescribed by the doctors.

The patient was an Irish woman of thirty-seven, sent by a family welfare society to the clinic for examination and treatment. The secretary of the society had previously written the social service department of the hospital, telling a little of the family situation. The woman was the mother of seven children under fourteen years of age, who were all undernourished and delicate. The husband had worked in a wax factory earning $21 a week, but at the time he was ill with bronchitis. The family welfare society had secured aid for the family in this crisis and a local dispensary was supervising the diet of the children. These facts were passed on to the examining physician who reported a diagnosis of goitre, ordered a metabolism test, and emphasized the importance of the patient's being free from worry. All this was explained to the family welfare society. Then followed a year's X-ray treatment of the patient at the clinic with periodic metabolism tests. All through these months the hospital social worker kept the secretary of the welfare society informed of the woman's condition, of the periods for her return for treatment, and explained away several misunderstandings. The husband was sent for at one time, that he might be told by the physician how necessary it was for the patient to be relieved from stress if treatment was to do her any good. When the patient failed to improve, convalescent care was arranged

for her and the younger children were sent to relatives. Again when she was not doing well and an operation was believed to be necessary, the hospital social worker passed on to the family welfare society the doctor's question whether or not there was some emotional disturbance at home which could account for the patient's failure to gain. With this clue, the secretary from the family welfare society visited the home and found the patient much disturbed because the husband had been reduced to half-time work and the children were not getting the food they needed. Every effort was made to relieve the patient's anxiety and she began to improve. Treatment was continued faithfully for six months, when she was discharged cured. For a year she has been well, apparently, and able to do her part in caring for her family.

In several cities the policies that should guide the functional relations of hospital social service departments and other social agencies have been clarified and formulated by a careful study of actual experience in working together.[1] During these years of experience a respect for one another's particular contribution has grown up, along with a conviction that to avoid duplication of work and to give patients the benefit of specially skilled social case work, some guiding rules of professional etiquette ought to be evolved. For example, if a person presents a temporary physical difficulty but a complex family problem in which the elements of industry, recreation, education, and character need strengthening, the hospital social worker would best serve that family by securing as soon

[1] See Wallerstein, Helen C.: The Functional Relations of Fifteen Case Working Agencies . . . and The Report of the Philadelphia Intake Committee. Philadelphia, Bureau for Social Research, Seybert Institution, 1919.

as possible the assistance of a family welfare society, letting it share in the acute problem presented by the patient's illness. It is often a temptation to hospital social workers to carry a family through the immediate crisis of social distress presented by sickness, while neglecting the more deep-seated social problem that lies behind it. A study of the end results of such a practice will many times show that, owing perhaps to the more pressing demands of other patients, a family had been neglected altogether after the crisis had passed. The worker should consider whether by a more far-sighted policy she cannot share the problems that she finds with others better able to serve the patient. She must not, however, consider another social agency as merely a convenience for ridding her of burdens. The thoughtful sharing of responsibilities should be worked out by conference between the hospital social worker and other social workers of the community, with such plasticity that service to the patient will always be the vital test.

Conferences on difficult individual cases are helpful in meeting certain situations. The expert social worker is willing to give her experience and advice even if the problem is not transferred to her for solution. Such consultation between specialists is not unlike the co-operative methods prevalent in medical practice. The oculist, aurist, neurologist, orthopedist, pediatrist, obstetrician, and general practitioner, each working in his own

field, is still appreciative of the other's knowledge and holds it essential to the honor of the profession to secure for a patient the advantage of special skill whether or not the patient himself has the ability to see the need. The general practitioner is able to determine when a specialist is indicated, but further consultation is often required to determine whether he should thereafter conduct the treatment under advice or whether he should pass over the case wholly to the specialist.

The hospital social worker should realize that while she herself may be an expert in the field of medical-social service, the scope of social work includes many other specialists. The family welfare societies may be considered the general practitioners, though they too have their specialty of considering more particularly the social problems which concern the family life as a whole. So the children's societies are the pediatrists of social work. Each specialist is developing a fund of knowledge which should be at the service of the hospital social worker, who in turn should realize that she too has acquired knowledge which she can share with others.

Specialism, unrelated and self-centered, has its dangers; that which appreciates its own field of work, sees its limitations, and calls others to supplement them is like one of our bodily functions when, in perfect co-ordination with other functions, it produces a happy state of health.

Specialization in social work should not be

merely a division of labor. Its justification lies in the development of particular skill, the purpose of which is better service. The rapidly developing councils of social agencies offer an opportunity for a corporate grouping of the various experts in social work and for a working out of their functional relationships. Medical-social workers ought to bring to such a council the knowledge and points of view yielded from experience with patients, doctors, and the administrators of a hospital, and in turn get from other social workers new conceptions of how a hospital can more fully serve the community and how a patient may be better served by the social agencies in a city.

The real measure of a community's strength for good lies, as has been indicated, not in the number and variety of its institutions, not alone in the personality or enthusiasm of its social workers, but in the effective joining of their forces. The effectiveness of such co-operative effort is a responsibility that rests upon each person who considers himself or herself a social worker.

# CHAPTER IX

## RECORDS

THE importance of well-constructed and thoughtful case records in medical-social work should need no argument. To record the abnormal conditions of the person in distress, the efforts put forth to eliminate these conditions, and the response to those efforts is as essential in social work as in medicine. Wherever we find a steady refinement of medical case records, with an increasingly accurate tabulation of necessary facts concerning the patient's family history, past history, habits and present complaints, the physical examination, the progress of his symptoms, and treatment, it is one of the most telling indications of improvement in the quality of medical practice. Good medical practice depends on this careful and intelligent registering of the progress of a case, both as an aid to thorough examination and treatment in each instance and—through the collective study and analysis of such records—as a means of improving the care of future patients.

The use of case records for teaching social and medical students is becoming an important means of instruction. Two sorts are of interest for the present discussion—the social and the medical. While social

records have received a good deal of consideration from thoughtful workers, they are less systematic in form and arrangement than medical records in hospitals. This is due partly to the fact that the professional technique of medicine is older, but also to difference in the kind of material to be recorded. Facts noted in medical records are concerned largely with conditions that can be tested by instruments of precision, such as the thermometer, stethoscope, microscope, and other laboratory procedure. With the development of the science of medicine, physicians have gradually discriminated between physical facts that are important and those that are unimportant in particular diseases. On the other hand, social conditions are to a larger degree dependent on personal observation and interpretation, and upon the testimony of people who are seldom trained observers. Thus accuracy is not so easily obtained.

Leaders in social case work have recognized the importance of thoroughness and exactitude and are gradually evolving a technique of conducting social examinations and of weighing social evidence.[1] They are also beginning to publish studies of the various types of social treatment. In the course of establishing this technique they have determined to some extent what facts are important to a good social record. The hospital social worker who is looking for a suitable kind of record for her

[1] For instance, see Richmond, Mary E.: Social Diagnosis. New York, Russell Sage Foundation, 1917.

work has therefore two types to study and to coordinate: (1) existing medical records (unsocialized); and (2) existing social records so far relatively uninfluenced by the medical factors in the cases recorded. Neither type supplies her with just the form she needs, but each is suggestive and each supplements the other.

Some hospital social workers who find it difficult or impossible to limit the number of their cases to those they can deal with efficiently, deliberately allow their records to remain for a time unwritten because any attempt to keep them up to date means the neglect of patients. But we cannot patch along in this way indefinitely; the work must be systematized. Another type of worker omits to make records because, while she finds a patient's distress very appealing, the record of it seems dry, dull, and academic. This is a superficial point of view and should never be tolerated by those responsible for standards in hospital social work. In every hospital, no matter how overtasked her department may be, the social worker should keep before her the ideal for which she strives by writing out in a few cases, at least, a satisfactory account of her plans and doings. This accomplishment will spur her on, because it is a tangible reminder of standards which she hopes ultimately to attain in all cases. By making a thorough analysis and giving continued consideration to the records of a few, she soon finds that these are more intelligently and satisfactorily

treated than are the unrecorded cases. Also, records furnish the most valuable arguments wherewith to convince trustees of the need for more time for case work or the need of an increase of workers.

The confidential nature of social case records should be recognized. They are necessarily intimate and personal. Unless there is a rigorous insistence on the protection of such records, we are betraying a trust. No worker has the right to secure the confidence of a patient, to get the details of his story, and then set them down for the perusal of any person who has not a legitimate need of the information. All records of social cases should be filed in cabinets that are kept locked except when a trustworthy person is in attendance. Access to particular records or their contents should be given only to those whose interest in the patient can be justified for his own sake or for that of someone else in similar need. A hospital will surely appreciate this point, since it is the attitude of doctors toward medical records.

In the course of an investigation by a state commission into the wages of women in industry, a social service department in a certain hospital was asked to allow those parts of the women patients' records that had to do with wages to be examined. In instances of this kind records that are not too intimate may be examined for an impersonal study which is justified by its contribution to social welfare.

Several types of records are in use in social service departments. The kind most commonly adopted is a general narrative following a uniform initial sheet on which are tabulated the items most essential for identification and reference. In a few departments, notably at the Boston Dispensary and the Boston Children's Hospital, the family unit is the basis; that is, the initial record sheet gives the family group and the patient merely as part of that group. Separate records are made for each additional member of the family who becomes a patient. In most social service departments, for example, at Bellevue Hospital, the University of Pennsylvania Hospital, and the Boston City Hospital, the individual is the basis of the record.[1] The first plan is that generally used by social agencies dealing with families; the second is that used by physicians writing records in medical institutions. There are varying opinions as to which form of record is the more practical and fitting for this field of work.[2]

Statistical and narrative records may be used for any or all of the following purposes, some of which have been previously mentioned:

(1) To aid the memory of the worker.

(2) To portray the conduct of the case so satisfactorily that a succeeding social worker shall have a complete history of all that has already been done.

[1] See Appendix, pp. 228–233.

[2] Farmer, Gertrude L.: Form of Record for Hospital Social Work. Philadelphia, J. B. Lippincott Co., 1921.

(3) To aid the study of methods of investigation or treatment and to contribute to their improvement.

(4) To provide material for case teaching as a means of instructing students in hospital social service.

(5) To promote medical-social research.

(6) To deepen and clarify the worker's reflections upon the problems that hospital social service encounters.

With discrimination in types of service rendered, methods and forms of recording will vary. We can see at present in social service departments a tendency to employ two forms: one an extended record of the case which gives a full social history of it, and the other a brief summary of service that involves little time but necessitates some social judgment on the worker's part.

When records are used chiefly as an aid to the memory, some workers have found it best to jot down brief notes while at work, and later, at intervals of two or three weeks, to write or dictate from these notes a summary of what has happened. Such a record is helpful to the worker in charge of the case, but does not portray the successive detailed steps of medical and social treatment, and may be limited in its usefulness to a successor obliged to take up the task. Also, it fails to show clearly what methods were used and in what order.

The most useful record to those who study methods of work narrates in detail and chrono-

logically the steps taken in the progress of the case and gives, as well, occasional summaries of accomplishment. These full records serve both for teaching methods of social case work and for the supervision of subordinate workers, when subordinates share in the treatment and the recording. The occasional summary has been found an aid in ready reference to different parts of the record. It also serves as a measure of what has been done, and should contain a brief statement of the most important steps taken, the results to date, and the problems still unsolved. All correspondence received and copies of important letters written are often valuable for reference and should be filed with other data in the case folder.

The length of a record is not a test of its value. Neither does a copious but indiscriminate accumulation of facts constitute a good record; these may, indeed, only add confusion to an already complicated story. The necessary details should be given as briefly yet as graphically as possible. A skilled medical-social worker will distinguish between the essential and non-essential facts in her records as well as in her work. In all six types of records careful distinction should be drawn between facts and impressions. The source of information should always be given. As the narrative proceeds, contradictory statements may have been obtained. The patient's point of view is often warped by ill-health, and it is always important to distinguish between the facts and his own interpretation of a

situation. There are sometimes intentional misrepresentations, the untruth of which appears only on further inquiry. The mother of a feeble-minded child, for instance, gave to the doctor at the hospital a history of severe beatings and cruelty from her drunken husband previous to the child's birth. She also said that her husband was dead. These statements were recorded on the medical as well as on the social record of this child. Further investigation, through the mother's family, through a physician who had known her for years, and through relatives of the father, proved that the woman was below par mentally and morally; that the father had never been a drunkard, and that he was still living, although he had long since ceased to live with his wife because of her immorality.

Although all patients who are under the care of the social worker have physical needs, the information necessary to an understanding of their problems is varied. That of the feeble-minded child or of a mentally deranged patient demands knowledge of facts not identical with those required for a wise handling of the case of a tuberculous patient or an unmarried girl facing motherhood. Thus, uniformity in methods of investigation, and in consequence uniformity in social records, is impossible in hospital social work just as it is in recording the multiform problems dealt with by other social agencies.

The initial record sheet adopted by a social ser-

vice department is usually uniform for all cases. The narrative record which follows is varied according to the type of problem presented and the amount of responsibility assumed by the department. The use of headings in the body of the narrative record serves as a guide in the orderly report of significant facts and helps to give uniformity and consistency to the record.

The narrative record of a tuberculous patient should contain such data as these: personal habits as to diet, sleep, exercise, care of mouth; knowledge of precautions against infecting others; health of other members of the household; history of previous attacks of pneumonia, bronchitis, pleurisy, or tuberculosis; home conditions in detail, with special reference to dusty, dark, or airless rooms and other unwholesome surroundings as well as to the opportunities for securing proper treatment there; employment—place, process, posture, kind of materials handled, hours and wages; possible resources for carrying out the plan of treatment.

The record of a child should lay chief emphasis on the home conditions, school history, relations between parents and child, and possibility of securing co-operation with its family.

Again, a record of a patient whose nervous condition is his chief source of difficulty calls for specific information about his heredity; his temperamental traits as interpreted by the patient and those about him; his relations with his family

and those who make up his social circle. His own attitude toward himself, his work, and life in general may also disclose facts of considerable value to the physician. These phases of the patient's personality are factors studied by the neurologist in his private practice, but the limitations of time in hospital and clinic make it practically impossible for the neurologist to get at such essential data. Hence, by helping to get them, the well-trained social worker can be a means of raising the quality of clinical treatment.

All these facts cannot be secured at the first interview, but without them a social worker cannot know her patient well enough to assist him intelligently. And the recording of the facts should be only preliminary to the social plan and treatment.

Some types of cases which are to be especially studied or analyzed, such as occupational diseases, feeble-mindedness, or other diseases with social bearings, can be more readily and systematically recorded on definite, detailed forms or schedules. When these schedules are exactly adapted to the object of the inquiry, their uniformity makes a subsequent study much simpler and more consistent. Such a schedule has been used in the Social Service Department of the Massachusetts General Hospital for a medical-social study of epileptic patients in the neurological clinic. The object of it was to secure consistency in studying the physical, social, and economic aspects of the subject.

A similar plan was carried out in a study of gonorrheal vaginitis in children at the Boston Dispensary and Massachusetts General Hospital. The close union of social and moral as well as physical factors in this disease makes it especially fitting that a study should include a search into all these aspects of it. Only on the basis of careful study from the three points of view can effective treatment or prevention be hoped for. All the patients were treated and studied simultaneously by the doctor and the medical-social worker. They could have no feeling that they were being investigated as types and ignored as individuals. Neither did the social worker suffer from the sense of helplessness common to students of social abuses who study the wrongs and must leave the wronged to their fate. In every case something was done toward righting the wrongs discovered.

Much of the investigation of occupational diseases has been directed toward the supposed connection between the occupation and the disease without regard to the personal habits and home conditions of the patients. If to be scientific is to be unprejudiced, we must in any search for truth consider all the known contributing causes. A hospital social service department might make important contributions to the elucidation of some of these social puzzles by bringing together expert knowledge of the bodily disease, the home, habits, and working conditions. In 1910 and 1911, the Social Service Department of the Massachusetts

General Hospital carried on, with Dr. Roger I. Lee, a study of 80 working girls who came to the out-patient department for treatment of diseases that indicated prolonged debility.[1] Each girl was given a thorough physical examination, and a social worker made a study of her habits, her home, and her work conditions. These accumulated facts in their interrelation were the basis of the study.

Dr. Lee's conclusion, that lack of opportunity for industrial training and for education in hygiene and thrift were chiefly responsible for keeping these girls in poor health, was reached with a due sense of how difficult it is to single out any one factor as *the* cause. Later an extensive study was made of a series of epileptic patients to ascertain their economic efficiency. To be thorough this study included consideration of the physical and social condition of each patient as well as the details of his industrial life.[2] Co-operative research of this sort by social workers and physicians has only begun; the future must show its benefits.

The use of records for statistical inquiry has been repeatedly exemplified in medical studies and social investigations. As the experience of hospital social workers increases, and as the volume of recorded cases is amplified, the records of these

[1] See Sixth Annual Report of the Social Service Department of the Massachusetts General Hospital, January 1, 1911, to January 1, 1912.

[2] See Ordway, Mabel, and Ryther, Margherita: "Economic Efficiency of Epileptic Patients," *Journal of Nervous and Mental Disease*, Vol. XLVII, No. 5, May, 1918, pp. 321–342.

cases are sure to be examined much more than hitherto by statistical methods. Obviously such examinations depend directly, for any fruitful results, on the detail and accuracy of the original statements. No reliable conclusions can be drawn from a statistical study of unreliable data. Thus the hospital social worker should feel it her duty to put conscientious effort into the permanent record of her day's work.

Another value of accumulated statistics, particularly in the early stages of a social service department, lies in the demonstration which they offer of the work which the department is conducting. Pioneer workers have secured local telephones, stenographers, and additional workers because they have kept account of the number of times they have had to walk to the telephone on another floor, the time it has taken to write records and letters in long hand, and the number of new patients referred. Kind-hearted directors will often notice the tired face of a social worker and possibly urge a vacation, when the real need is better equipment for work or an increase of staff. However, the best argument for more assistants is a statistical statement of the bulk of the work. Facts rather than vague impressions or an atmosphere of busyness should be the basis of argument for assistance. A supervising group, if members care for real efficiency in the department and have conception of what social service demands of the

worker, will be influenced by graphic, statistical statements.

Most departments keep account of the new patients for the year, the number of old patients, visits made, the nationality, age, sex, and illness of each patient, as well as the sources from which they are referred. Thoughtful workers are analyzing the types of social problems presented. Some departments make careful records of the extent of their co-operation with other agencies. Such statistics filed from year to year indicate not only the increasing extent to which these other social agencies serve patients, but they stimulate the resourcefulness of the hospital social worker. Statistics that set forth the true volume of work; that disclose any especially large problem, such as tuberculosis or children's diseases; that show the use of other agencies by the workers—all these help to tell the story of what the department is doing and what its policies are.

It is important not to become stereotyped in the recording of our statistical material. Yet it is well to keep on file data that has been compiled from time to time, for the further reason that an analysis of the department's activities at a given time is made doubly valuable by comparison with previous figures. An accumulation of careful records and accurate interpretation of them may be made the legitimate basis for a plea for some special object. A hospital social worker in St. Louis showed, through accumulated statistics,

that the crippled children who had come to the hospital for braces and supervision were having no opportunities for education. She found that 102 of the children under the care of the hospital for one year, were of school age but not attending school. Practically all of these children were well enough to receive instruction, but the long hours and the ordinary seats and desks in the public schools were not suited to their condition. The community that neglects the education of its crippled children is laying up for itself many future problems. This was the argument of the hospital social worker who urged for the St. Louis cripples not only public school instruction in regular elementary branches, but also industrial training that would help them to self-support. As has been noted, a special teacher for the children in the Boston City Hospital was secured from the city department of education through a similar statistical study.

In most hospital departments it has not been deemed convenient to file together the detailed medical and social records; medical records are usually filed in one room, social records in another. An exception to this is seen in some of the psychiatric clinics and hospitals and in the Sloane Maternity Hospital. It has, however, been found important that the doctor who is studying the medical record or treating the physical needs of a patient who happens to be one of the few studied socially, should know that the social worker has

also done some work on his case. The existence of this additional data should be noted on the medical record. Most social service departments have devised some means of giving this information, as, for instance, stamping in red ink, "Social Service Dept.," on the medical record.

As the physicians realize more clearly the bearings of social facts on the diagnosis and treatment of disease, the number entered on the medical record increases. In my estimation the social facts secured by the medical-social worker and of importance for diagnosis and treatment should have a place on the medical record—I mean such facts as a family history of mental disease, unwholesome occupation, peculiar traits of character, and habits, as well as such adverse social conditions as would jeopardize treatment. It must be granted, however, that detailed statements of procedure in the social conduct of the case would, if added to the medical record, merely make it impractical for ready use. Also, it has been agreed that the intimate details of the social record should not be filed with the medical record which later, on some occasions, might be summoned by the court. The physician who is and always must be chiefly concerned with the medical technique of the case, does not always find the details of social technique especially interesting. Neither are details of medical conditions and treatment required on the social records when the medical record is available. Means of identification, by cross-references between social

and medical records, will, of course, be always valuable.

The importance of selecting such social facts as are pertinent to all medical records has received the attention of some hospital physicians and hospital social workers. In some clinics—at the Boston Dispensary, for instance—the social worker takes the patient's initial history, which includes chiefly social data. In one dispensary the medical record of each patient admitted is filed in a folder on the outside of which are recorded the following facts: name, address, year of birth, civil state, sex, nationality, occupation, kind of material handled, and employer's name. This information is gathered for the benefit of the admitting officer and physician, not for the social service department. It is interesting to note that the item concerning occupation, with a statement as to the employer's name and the kind of material handled, is filled out by the physician examining the patient. Thus, the possible relation of the patient's disease and his occupation is brought to the doctor's mind. Many hospitals have recorded, as a matter of routine, the patient's occupation in the medical record, but have failed to enter the particular branch within the industry upon which the worker specialized. This has rendered the item of little value. For instance, the occupation may be given as "laborer," and may mean any of fifty different kinds of work under that name. It may be given as "shoe factory" and mean anything from laster

to packer. The dangers to health in these two kinds of work in a shoe factory vary greatly.

In the Boston Children's Hospital and the Detroit Children's Hospital the social workers report to the physician on the home conditions of all patients. At the request of the physician their recommendations concerning the after-care of the children are incorporated in the medical records. Social workers are considered specialists who have knowledge and judgment to contribute to the consideration of the cases.

The hospital social worker, through her case work and her familiarity with social conditions, has constant opportunity to bring important social facts to the attention of the physician. She does well to feel her responsibility and recognize her opportunity. To make her contribution valuable she must know her subject, for medicine is properly a conservative profession which accepts new types of knowledge only as they prove themselves of real benefit in the treatment of disease.

# CHAPTER X

## ORGANIZATION

HOSPITAL social service, in the minds of its initiators, is not an independent enterprise, but an essential part of hospital procedure. Those who first engaged in this branch of service believed that until the influence of social conditions was fully recognized and acted upon by the hospital management and physician, medical efficiency would be impossible. But this truth had to be proved before it could be accepted by hospital authorities and before their trustees could feel justified in expending funds for the support of social work which they construed as non-medical and therefore non-essential in a medical institution. This is natural enough, for many other initial experiments, such as kindergartens, playgrounds, visiting teachers, and school nurses were made through the interest of persons who had a vision of the possibilities and practical value of these new developments and were willing to provide special funds for their demonstration. For like reason, when the initial social service department was established in 1905 at the Massachusetts General Hospital, it was for several years supported by special funds.

The principles on which the department at the

Massachusetts General Hospital is based have now been accepted by many as fundamental to thorough hospital work. But the most suitable form of organization for carrying out these principles is still a matter involving varied opinions. A few axioms of organization are accepted; but the relation of social service to the hospital administration and to the doctors; the methods of deciding what patients shall have the service of the department; and the best methods of co-operating with other social agencies in the city, are all details still to a large extent in process of being worked out.

Several forms of organization are in use in social service departments today. While it is as yet impossible to class any as ideal, one principle has been generally accepted; namely, that *a social service department to be most effective must exist as an integral part of the hospital, not as an affiliated agency.* For the present it is impossible or impracticable in some places to conform to this administrative principle, but it is the one most likely to prevail in the end.

Among the various forms of organization the following are some of the distinctive types:

1. Those established and controlled by the hospital board; like the Social Service Department of the Boston Dispensary.

2. Those established by hospital authority and affiliated with the training school for nurses; such as the Social Service Bureau at Bellevue Hospital, New York, and at Cook County Hospital, Chicago.

3. Those initiated by an individual or small group of individuals and supervised by a self-appointed committee recognized by the hospital; such as the department at the University of Pennsylvania Hospital, Philadelphia.

4. Those initiated and supervised by an outside agency, such as the American Red Cross or the National Catholic Welfare Council.

Wherever hospital social service needs to be interpreted and explained to skeptical hospital authorities, to physicians, and community, and wherever it is dependent for financial support upon private sources, an advisory committee is of great help, even though the final control remains in the hands of the hospital. When standards of work have been evolved and generally accepted, and there are in the field thoroughly trained workers free to develop the department according to accepted standards of social work, less responsibility for details will rest on the supervisory committee.

Social service committees, as they are frequently called, are often composed of women who have been interested in a hospital through a ladies' aid committee or a board of women visitors. Troubled by the sight of diverse social needs among the patients, they usually welcome the advent of hospital social service as an important aid. In some instances the women on the committee have paid the salary of a worker and served as volunteers under her. But though these committees supervise the work in certain details, the ultimate control of

policies usually rests with the hospital board. Such a group acting in a supervisory capacity contributes personal service and enthusiasm, but it may lack the advantages of the more diversified group in which the hospital physicians and trained social workers balance the point of view of the laity and bring expert knowledge to the complicated problems that come up for settlement.

The type of plan is largely determined by the source of the interest that projected the department and by the source of financial support. But the purpose should be to bring into effective functional relationship all the various individuals, hospital departments, and social agencies that are required for the social welfare of the patients. The essential elements of growth are not present unless there is developed a vital relationship with the medical staff, the hospital administration, and the social agencies of the community. While from the beginning it is important that responsibility and authority should be clearly determined, it should be recognized that a new and developing service in a long established institution like a hospital, should be free to work out the relationships necessary to the performance of an unique function.

The Survey of Hospital Social Work made by the American Hospital Association in 1920 declared certain principles of organization that may well be quoted here, as they are generally accepted by those who have seriously considered the matter. They are as follows:

(a) As a fundamental general principle, social service should be organized as a department of the hospital, dispensary, or other institution. Assistance or participation by outside individuals or agencies in starting a social service department may well be accepted, but the department should be placed from the beginning, or the earliest possible date, under the complete administrative control of the trustees or other governing authority of the institution. No other arrangement can be deemed permanently satisfactory.

(b) This form of organization implies the direct responsibility of the head worker of the department to the superintendent or chief executive officer of the hospital or dispensary.

(c) There should be an advisory committee for the social service department appointed by the Board of Trustees which should include representatives of the following elements: the trustees; the medical staff, professional social workers of standing in the community; non-professional laymen or women, with experience or connection with social work or community problems; the superintendent of the institution; the superintendent of the training school; the head worker of the social service department should be an ex-officio member of the Committee. . . .

(d) The Social Service Advisory Committee should meet at regular intervals for the discussion of the problems and needs of the department, for hearing reports of its work, and for making recommendations to the trustees regarding the work itself. The trustees or superintendent should look naturally to this committee for aid in determining and guiding this relatively new branch of hospital activity.

(e) As to finances the social service department should be maintained as part of the hospital budget, and its funds, from whatever sources derived, should be administered through the usu al hospital procedure. . . .[1]

[1] Report of the Committee Making a Survey of Hospital Social Service, American Hospital Association, Bulletin No. 23, Chicago, November, 1920, pp. 5–6.

No plan for supervision or ultimate authority can be substituted for the leadership of a well-trained head social worker. She must of necessity have the immediate supervision of the detailed work, though her point of view and judgment may be supplemented by such an advisory committee as is suggested by the survey report. The Massachusetts General Hospital Social Service Department has such an advisory committee, which was a supervisory committee responsible for the support of the work until in 1919 the department became an official part of the hospital. It numbers among its members the superintendent of the hospital, one of the board of lady visitors (who is also a trustee), a member of the training school committee, several members of the medical staff (two medical men, one surgeon, one pediatrist, the orthopedists, one neurologist), two trained social workers, and one business man. The diversity of experience contributed by such a committee is valuable, and its discussion of matters important to the department is well balanced. It also gives a consistency and stability to the department through years of changes in staff and hospital personnel, and an accumulation of knowledge of the problems that the department has had to meet.

## HOW AND WHERE TO BEGIN

Undoubtedly the most important first step in starting a department is in the selection of a qualified medical-social worker to take charge. There

is no substitute for this essential element to success.

In the second place, it is very necessary to have the work welcomed by both administration and medical staff, and to give the head worker time to survey the situation both in the hospital and in the community—to get her bearings and to make her tentative plans for both the immediate and future developments. If she were given a month in which to study the situation, free from any detailed responsibilities, she would save time in the end and could plan her work with much more intelligence.

This first month might well be spent getting answers to the following questions:

(a) What is the history of the institution? the purpose of its foundation? the ideals of those who promoted its establishment? Answers to these questions often explain traditions or forms of organization or affiliation not clear on the surface but which, nevertheless, help to determine its policies. For instance, the charter of one of the older hospitals disclosed a very definite pledge to a threefold purpose of care of the sick, teaching of medical students, and medical research. No social service department could work intelligently in that institution without recognizing these foundation purposes and taking its part in strengthening them. Early reports almost invariably express the original social purpose of an institution, and the recalling of these ideals often suggests a central motive of service to

the patients that clearly justifies a social service department.

(b) What is the form of organization of the hospital? What is its controlling body? How are its members appointed? How is the medical staff appointed?

(c) Who are the patients? What does the annual report disclose as to their residence, nationality, occupation, economic status, length of stay, age, most important diagnoses? What are the restrictions and methods of admission?

(d) Are there at present or has there been any social service in the hospital? How can it be related to the new department? Who is interested in the establishment of this department?

(e) What are the community resources with which the hospital social worker will probably be able to co-operate? Are there agencies for family welfare, child care, public health nursing? What public health organizations exist? Is there a central council of social agencies and a social service exchange? What are the facilities for institutional care of the tuberculous, the mentally diseased, or any special groups with which the hospital is concerned? What are the characteristics of the community in size, congestion, nationalities, industries?

With closer focus on her immediate task she should have an opportunity to observe the hospital routine in various connections, such as admission and discharge, visiting hours, the conduct of clinics,

the recording system, the rounds of administration officers, of head nurses, or medical staff.

Such a superficial examination as one trained for hospital social service could make in the course of two or three weeks would enable her to secure a background of the hospital to which her more intimate knowledge can be added as work with patients reveals more clearly the problems that exist and the practical resources at hand to meet them.

The question of where to begin is usually a troublesome one. But one principle has been quite clearly demonstrated, that the work should start, if possible, at whatever point assures the greatest interest of the medical staff. If their interest is chiefly in administration, the social service to the patients, at admission or discharge, for instance, should be related definitely to the medical service. The first few months of the department should serve as important evidence to doctors, administration, and nurses of the aims and functions of social work in hospital treatment. In spite of the extensive demonstrations that have been carried on for several years, it still seems necessary in each new department to prove the usefulness of the work to skeptical people. Some value lies in this challenge. But it should be remembered that the only satisfactory argument is continued good work and definite results achieved in service to patients and through them to hospital and community.

## PRELIMINARY MEDICAL-SOCIAL SURVEYS

In many instances it has been found worth while to make a simple study of a clinic or ward service previous to starting social service in connection with it, for in several places results of the study have changed the plans for carrying on the work.[1] For example: A survey of the Children's Clinic at the Massachusetts General Hospital, covering a period of six months, was made to ascertain the basis on which to organize social work in that clinic. The schedule sheet for this survey was formulated by the visiting physician with the co-operation of the social service department of the hospital. One of the interesting results of this inquiry was the revelation of the fact that the largest group of children coming to the clinic were under one year of age, while the impression had existed that this was a "clinic of school children." Another fact brought out was that, out of 779 children applying in the six months, 426 came to the clinic only once. A further analysis of these 426 children showed that these one-visit patients represented 59 per cent of those in the study suffering from improper feeding, 52 per cent of those with chorea, 56 per cent of those with bronchitis, 26 per cent of those with heart disease, and 12 per cent of those with tuberculosis. These facts influenced the doctors and the social service department to establish first a follow-up system for the entire children's clinic, to place a physician and public health nurse

[1] See Appendix, p. 237.

in charge of the babies, and lastly to assign one social worker to children with heart disease.

There are many other illustrations of the value of a preliminary survey; possibly most suggestive are the inquiries made by the Social Service Department of the Boston City Hospital, where it has been the policy of the director, Gertrude L. Farmer, to make one for each ward or clinic before placing a social worker. Several of these studies are published in the 1914 to 1917 reports of the Department.

Surveys made after a period of time to test the value of a particular service are sometimes significant. For instance, at the Eye Clinic of the Boston Dispensary, a study was made of the records of all the new patients who came to the clinic for three months in 1910 (263 patients), and again for three months in 1912 (301 patients). Social service was begun in the clinic in 1911. In 1910, 66⅔ per cent of all glasses prescribed by the oculist had not been called for. During a corresponding three months in 1912 only 8 per cent of the glasses prescribed were not called for. There was also an increase in the number of visits made at the clinic by patients with iritis and keratitis. The number of visits per patient increased 50 per cent after social service was established. The number of patients cured increased from 9 per cent in 1910 to 31 per cent in 1912; the number improved from 44 per cent to 55 per cent, while the patients lost sight of decreased from 37 per cent to 14 per cent.

Similar surveys of the Mental Clinic records of the same institution were made, the object of the latter being "an impersonal self-criticism, gaining not only indications of the strength and weakness in the work but suggestions for the improvement of methods and attainment of results with a minimum of effort and expense." The second study was made after the medical-social worker had joined the clinic. Significant facts brought out by these studies showed the value of social service to the clinic. During 1911, 59 per cent of the patients had been lost sight of, while during the six months of 1912 covered by the later study only 5 per cent were lost. During the first period, 80 per cent of the patients had "deferred diagnoses"; that is, no diagnoses at all, while during the second period only 9 per cent had deferred diagnoses. It was also brought out that 40 per cent of the mental cases treated in the clinic during the second period were transferred to other institutions for care, as compared with 16 per cent during the first period.

All these surveys, although limited, have disclosed clearly some of the haphazard methods now used in the treatment of dispensary patients, have given us a rough test of efficiency in dispensary service, and have brought out some defects that can be and are being rectified.

## SELECTION OF PATIENTS FOR SOCIAL SERVICE

Three general methods of selection of cases have been customary: First, that of having the social

workers themselves seek out possible problems in their field, either at the admission desk, in the clinics, in the wards, or by deliberate choice of certain types—of unmarried pregnant girls, for example; second, selection and reference of patients by the nurses, or by the hospital committees visiting in the wards; third, dependence on physicians for the selection and reference of patients.

Some of the workers who have stood firmly for the third method interpret hospital social service as an adjunct of clinical medical service, and hold that, until the department is well established, the only way to assure the development of medical-social work is to secure the interest of physicians by taking only such cases as are referred by them. This would make each patient accepted a means of demonstration of medical-social relations in diagnosis and treatment. The reference of patients by the doctor may be direct or by means of slips similar to those used for prescriptions.[1] The physician indicates on the blank the physical treatment, suggests the social need, and refers him to the social service department. Such a process, however, is more or less indiscriminate. The busy physician has neither the time nor the special knowledge to select those most in need of social assistance. On the other hand, if the social worker chooses patients wholly by reason of what she learns on the social side, she is not necessarily selecting those most in need of medical-social care; her attitude

[1] See Appendix, p. 223.

toward the patient is too far removed from the consideration of his physical condition.

Wherever the first and second methods prevail it has been clear that medical-social work can develop vitally only if the worker, after having the social difficulties called to her attention, is careful to treat them in very close relation to the medical service. As physicians and social workers through the practice of these interrelations come to appreciate each other's particular methods, the type of case likely to be suited for this joint service will become clear.

For example, it is not uncommon to find, under the supervision of the head of the department, workers in charge of tuberculous patients, children, psychoneurotics, patients with venereal disease, cripples, and the physically handicapped. Provision for care in these fields does not necessarily indicate the chief social needs of the institution. The call for a special worker for psychoneurotics may result from the interest of some physician who desires to refer to the department many patients who should have more attention than he can give them. A special worker for children, for unmarried mothers, or for the handicapped may be placed in the department by some donor concerned about that type of unfortunates.

A wave of hopefulness about the cure of tuberculosis—to take a familiar instance—leads to the appointment of some workers. Others serve a physician's particular interest, such as chorea.

Others create their own position by the strength of a dominating personality. Yet all the while, hundreds of wretched patients may go quite unaided, not because their need of help is not recognized, but because a hospital is powerless to understand.

The social worker has usually made her greatest effort in whatever direction she has found the superintendent, the doctors, or the nurses most sympathetic. This effort has often been neither satisfactory nor systematic, and no one has felt the lack more than the workers themselves; but the opportunities seized have served to develop methods and to prove the necessity of social work in clinic and ward. We now require more comprehensive methods of measuring the need of social service in given institutions, and of organizing plans to more effectively cover those needs.

In a suggestive paper on the Social Aspects of a Medical Institution, read at the National Conference of Charities and Correction in 1912, Michael M. Davis, Jr., then director of the Boston Dispensary, pointed out that the next step in the development of hospital social service would probably be an adequate plan for selecting the patients who require social treatment in order to make medical treatment effective. He believed that the social necessities of all who resort to a medical institution had never been measured, and that any general estimate based on a comparatively small group of patients referred to the social service department was not sound. Basing his classification

on a medical-social study of the new patients coming to the Boston Dispensary on three different days, he classified tentatively under four headings the problems, social as well as medical, which presented themselves:[1]

Type One. Patients whose social problems are evident and acute. These problems must be solved promptly if the patient is to be in a position to receive any effective treatment.

*Examples:* A baby of fifteen months, ill-nourished, enlarged tonsils, pharyngitis. Mother a dishwasher in a restaurant, deserted by husband.

Married woman of forty, chronic arthritis of phalanges of right hand, scoliosis, teeth almost gone, severe headaches. Takes bromo-seltzer in large quantities. Cannot understand English. Three children at school, husband a tailor.

Young unmarried woman, illegitimate child. Both syphilitic.

Type Two. Patients whose social problem is not acute, but whose disease is one dangerous to others. It is a serious matter if a patient suffering from such a disease goes about without continued care and ultimate cure. The interests of the community in such a case are paramount to the needs or wishes of the individual patient.

*Examples:* Woman of twenty-one, recently married. Syphilis. Syphilitic throat lesions.

Married man of thirty-two, second stage tuberculosis; two children of school age and baby under two.

Type Three. In this type there exists no acute problem of poverty, ignorance, or employment; but examination at the first visit indicates a disease which means that the patient should return several times for treatment. Unless the work of the physician who makes the diagnosis is to be wasted, so far as service to the patient and the community is concerned, this return should be brought about. It is the duty of the

[1] See Appendix, pp. 234–235.

institution to adapt its methods so that patients are most likely to return, and so that the most economical and efficient means are used for following up patients to such an extent as is necessary without squandering effort upon hopeless or unresponsive cases.

*Examples.* Man of fifty-two, married, no children. Clerk. Rheumatism.

Woman of fifty-three, married, two children, one at school and one working; husband a laborer, work unsteady. Indigestion and bad teeth.

Boy, age four. Father is a helper in a garage. Three other children, one working. Adenoids, hypertrophied tonsils, operative; dermatitis.

Type Four. No acute social problem exists and treatment of patient can be completed at the first visit, or, if a few additional treatments be required, the disorder is such as to occasion discomfort sufficient to insure patient's return.

*Examples:* Toothache, requiring extraction; supposed need for eyeglasses found on examination not to exist; stye on the eyelid.

What is the relative proportion of these types?

From a study at the Boston Dispensary I can say tentatively:

Type One and Type Two (acute problems calling for medical-social case work); 25 to 30 per cent of all patients.

Type Three (problems requiring social work but mainly by clinical methods); 40 to 50 per cent.

Type Four (patients not requiring any following up or other definite social work); 25 per cent.

In explanation of this Mr. Davis goes on to say:

These percentages are, of course, tentative even for the single institution to which they refer. But I believe that this kind of classification is of fundamental importance to the social work of medical institutions. Such work falls into two main types, which for the sake of better titles I will call the "case work type" and the "clinical type." To the latter

very little attention has thus far been given. It seems that it would apply to one-half of all the patients, while the kind of work with which we are most familiar, the case work type, appears to apply to less than one-third. The clinical type of social work requires persons as well trained as those who pursue case work—for most individuals carry on both kinds, though with different patients—but the clinical work is not necessarily pursued according to those methods or with that point of view which has usually been regarded as effective in the care and rehabilitation of needy families in their homes.

Since this study and similar ones that have been undertaken elsewhere we have made some progress in selection of cases. The Boston Dispensary has seen the development of the experiment of placing the medical-social worker as the clinic executive[1] who should review the requirements of all patients as they come to the clinic and bring to the surface any social difficulties that will jeopardize medical treatment. The soundest policy must include medical as well as social judgment. One of the problems of the clinic executive is to keep sufficiently free from pressure to retain her fresh judgment and avoid routine procedure and thinking.

### THE SOCIAL WORKER AT THE ADMISSION DESK

The admission desk has proved to be a strategic point at which to learn about the social complications of patients. In several dispensaries—Boston Dispensary, Cambridge Hospital, and Memorial Hospital at Worcester, for example—the social

[1] Lovell, Bertha C.: "The Clinic Executive in an Out-patient Department," *The Modern Hospital*, June, 1919, Vol. XII, pp. 470–472. Also, Lovell, Bertha C.: "The Social Worker as Clinic Executive," *The Modern Hospital*, August, 1919, Vol. XIII, pp. 153–155.

worker is placed at the admission desk. Her first duty, like that of the lady almoner in London hospitals, is to pass on the question of admission of patients to free treatment by an inquiry into their financial status. In most instances she is also on the lookout for patients needing social service. It is of great importance to have at the admission desk someone possessing social knowledge and human sympathy.

The admitting physician who knows little of the widely varying standards of living among patients, of the range of wages for various occupations, of the seasonal trades with their irregular incomes, and of the cost of living, has not a sound basis on which to determine whether or not patients applying for treatment are suitable for admission to a free clinic or for free hospital care.

It is no more possible to make a social diagnosis by seeing the clothes people wear than to make a medical diagnosis with one's eyes shut. I once knew a patient who borrowed the best clothes of the whole family when she came to the hospital, out of a more or less conscious respect for the institution. She looked as though she could pay, although in reality she was barely able to get along because of irregularity in her work and income and her precarious health. If a dispensary claims to exist solely for people of a certain economic status, then the admission officer ought to be capable of making a discriminating social judgment. But the exclusion of those able to pay a private physician is

not the sole function of the social worker who may be placed at the admission desk.

In the third annual report of the Massachusetts Charitable Eye and Ear Infirmary of Boston some of the opportunities of the social worker at the admission desk are brought out:

The Registration Department of a hospital, usually considered a cut and dried, most impersonal piece of work, is in reality the most interesting of the hospital departments. When you have asked a patient his name, his age, his birthplace, his present address, his occupation and wages, you know a great deal about him. . . .

Mrs. Antonio Luigi comes to the registration desk with little Tony, eyes much inflamed.

"What is the little boy's name?" answered fully, "Tony Luigi, same his fada's name."

"How old is he?"

"Nexta mont' tree year."

"Where was he born, in Italy?"

"Geno', ten mont' an' he come here."

"What is his father's work?"

"Pick and shovel, but he no work now. He seecka da bed now tree week, seeck, alla time."

"Hasn't he had a doctor or gone to a hospital?"

"No doct', no hospitale."

"What seems to be the trouble?"

"Oh, he cough, cough alla time."

And when you have registered Tony, you know that he is one of five children; that his parents have been in America two years; that his father is a laborer who has had irregular work; that the family has lived in three rooms in a crowded neighborhood on an average of $5.00 a week; and that the father is not improbably tuberculous.[1]

[1] The report from which this is quoted appeared in 1909. Since then, social workers have learned to regard such items as are summarized in the last paragraph as statements forming a good basis for further observation and inquiry.

Another social worker who has had experience at the admission desk says:

The interest shown at the registration desk brings the patients back to it with a statement of their special difficulty or problem.

Margaret Carney, a widow, fifty years of age, lives in a nearby city. At the registration desk it is learned that she has been a mill worker, but because of failing eyesight she has been unemployed for some months. The support of the family is a child, also a mill worker, who earns $5.50 a week.[1] Later she returns to the registration desk to say that she is unable to pay for the medicines which have been prescribed by the doctor and she will be unable to return in two days, as he has asked her to do, because of the expense. Free medicine is secured for her and she is referred to a charitable society in her home city for the necessary help to enable her to return. This society wrote in reply that such help would be given her and that she is "an old friend." During a period of nine months she returned when it was necessary and her vision improved greatly, so that she was able to work when work was to be found.

It is at the admission desk that the social worker can get the pulse of the hospital, as the stream of humanity passes through her hands seeking the services of the institution. It may be her duty to know whence this flood comes and whither it goes. She may be commissioned to find out why and how the community uses such service as the hospital gives. Such a medical-social worker is placed at the admission desk of the Boston Dispensary. Her duty is not only to pass on the admission of patients to a free clinic, but to be the student who

[1] These are the wages of ten years ago.

analyzes the dispensary population in its social bearings. If, while admitting a patient, she learns facts that are of importance to the physician, she passes them on to the clinic. Her chief function, however, is in the field of medical-social investigation. It is for her to study the economic groups which the hospital serves, the question of "hospital and dispensary abuse," the alternative for patients refused admission to a free clinic, and the relation of the dispensary to other medical and charitable institutions. She may also guide medical-social researches, as, for example, in occupational diseases, industrial accidents, and the cost of medical service to patients at various economic levels.

Several hospitals employ social workers to determine board rates; for example, the Pennsylvania Hospital and the Protestant Episcopal Hospital in Philadelphia. There are differences of opinion among thoughtful people as to whether such workers should be a part of a social service department; some maintaining that it is a disadvantage to have any member of the social department identified with the financial relations of hospital and patient, while others maintain that the just fixing of board rates is an opportunity to make the patient feel that the hospital is interested in his welfare, and that, in the process of getting the necessary facts, social problems are revealed which make the correlation of social service with this function entirely consistent.

Thus it will be seen that not only the organization but the function of social service in a hospital is not quite clear as yet. This is not due to careless thinking, but chiefly to the fact that the hospital in its growing and varied community relations and in its varied services to patients is constantly finding that social facts and methods are useful to the administration as well as to the medical service. For example, social workers are being asked by the administration to relieve the congestion of wards by the suitable placement of chronic patients who do not need care in an acute ward, also to procure interpreters for foreign-speaking patients and to assist discharged patients who have no suitable place to return to or no means of getting to their homes. It is the custom of some hospitals to have the social service department assist in the development of policies between the hospital and local and state social agencies; in some, social workers are helping to establish occupational therapy and hospital libraries; in others, physicians are asking for social workers to assist in researches that involve securing social data. Training schools for nurses are seeking instruction for their pupils in the social aspects of hospital work. Medical schools are looking to social service for instruction of students in the social elements of medicine. Work in all these directions influences not only the scope of the social service department, but the conception of its function and its organization. One central fact seems to stand out clearly; namely, that none of these

varied services to the patients, to the administration, to research, and to teaching can be kept sound unless a daily part of the department's work is a body of careful social case study. This study will serve as a constant challenge to those who may otherwise become too theoretical, as well as to hospital policies that may become too rigid to truly serve the patients. Organization ought to be a vital, living thing, not a crystallized form. It should be plastic enough to adapt itself to every step in the sound growth of hospital social service as an integral part of the institution. Social workers should help to keep fresh in the minds of all who work within the hospital walls the consciousness that not the separate but the combined results of hospital activities are far-reaching and essential to the well-being of a community.

# CHAPTER XI

## WORKERS

THE choice of workers is the most important consideration in the development of a social service department. The qualifications desirable are many and varied, since she must not only be able to give skilled service to the patients, but also must contrive to bridge the gap between the community and its servant the hospital. She can make each more conscious of the other, and can guide each to draw more fully upon the other's resources. Social service has been carried on most pleasantly in some hospitals without stimulating either the work of the physician or that of the local social agencies. But this is not the kind we are discussing. Often the only gain has been a little more kindness to patients. Without underestimating the value of personal kindliness in an institution where it is so imperatively needed, I wish to point out that it is only one aspect, not by any means the whole, of hospital social service. A physician connected with a hospital that "had social service" testified that he knew of nothing that the worker did except to visit the ward in the capacity of a friend; he had never "come in contact with her in his work," and could tell little about her value; he

believed she was much appreciated by the patients. Skilled social work, like nursing, includes acts prompted by kindly interest; but it should include far more. A social worker who has failed to give at least some of the physicians in the hospital a definite sense of her value, in helping to make treatment effective, has failed to perform the sort of service which is considered in this book.

The social worker must even sometimes be a disturbing element if she is to make her proper contribution. Any innovation in a conservative institution is likely to be a bit disconcerting, not in the sense of producing useless irritation, but by disturbing some old habits. The worker should have this quality of stimulating without annoying others, both within and without the hospital. Miss Richmond's test of fitness, which she would apply to the social case worker, is especially applicable to the social worker who would seek the privilege of service in a hospital—an institution in which the greatest variety of human problems are congregated, and in which human life is seen in all its beauty and strength and frailty. She says that social workers must have in their hearts a "conviction of the infinite worth of our common humanity before they can be fit to do any form of social work whatsoever. Life itself achieves significance and value not from the esoteric things shared by a few, but from the great common experiences of the race—from the issues of birth and death, of affection satisfied and affection frustrated, from those

chances and hazards of daily living that come to all men. Unless these conditions common to all humanity strongly appeal to us, or until they do, we are not ready to adopt social case work as our major interest."[1]

The hospital social worker should have a comprehensive knowledge of the general field of social work, and technical skill as well as personal qualities for case work. She should be a person of education and broad outlook, with a capacity for understanding many points of view. She will need the ability to teach, together with the receptiveness of a student. Finally, she should have organizing power, open-mindedness, and that discriminating sense of values which implies a sense of humor. These qualifications can be in part acquired through training, but to a larger degree they are matters of native endowment. Possessing them, the worker will not only bring effectiveness to her daily tasks, but will remain sufficiently plastic to increase her efficiency through experience.

If there is to be but one worker, the task of choosing her is more difficult than if she is to be one of a group. Workers may be so selected as to supplement one another and assure a variety of desirable qualities in the whole group. For instance, during the early years of the hospital social service movement, the trained social worker without medical

[1] Richmond, Mary E.: What Is Social Case Work? p. 249. New York, Russell Sage Foundation, 1922.

knowledge and the trained nurse without social knowledge often did splendid team-work, each having a due appreciation of the other's contribution to the department.

For the pioneer worker, steadfastness of purpose and patience are essential assets. No matter how much she may bring to this new field, she has to win her way step by step; for in no hospital is the path wholly clear for the introduction and growth of social work. While many may sympathize with her efforts, others will be indifferent; some even may be antagonistic and regard her advent as a criticism of a "well-ordered institution" rather than a promise of increased efficiency. She must have faith in the gifts she brings and an enthusiasm that will make the challenge of criticism a stimulus rather than a depressant to her. Consistent, thorough work will finally be recognized, and efforts that are wisely guided always justify themselves within a few years. It is well to remember that we are working for the future as well as for the present conduct of hospitals.

The ability to co-operate easily with the physician is obviously necessary and for various reasons, as is also a sympathetic understanding of the well-seasoned purposes and often disappointed hopes of medical treatment. The medical-social worker should know how to reinforce these and how to secure from medical record and doctor definite information about the medical plan for the patient. She should also acquaint the physicians with her

own plans and the results of her efforts for the patient. In talking with them she should avoid interference with any routine that saves their time. Physicians are usually generous in explaining to hospital social workers the important facts about a patient's physical condition that do not appear on the medical record. They are beginning to recognize, in turn, that they must often learn from the social worker the significance of social diagnosis and treatment. Doctors, nurses, social workers, and patients are alternately teachers and students, giving and receiving according to their lights.

If the hospital social worker is to be the community's interpreter, if she is to make the institution she serves conscious of its external relations, she must see it from the point of view of the laity, as well as the community from the point of view of the institution. Outside the hospital she should live as nearly as possible the wholesome life of any other citizen, and continually strive to see the hospital as it looks to the stranger within its gates. On the other hand, if her work is in a large hospital, her understanding of the huge, complex, and busy institution will often enable her to interpret to outside charitable agencies some of the mysteries and paradoxes of its rules which they do not readily appreciate. The necessity for "red tape"; the admission, classification, and discharge of patients; the physician's professional point of view, his secrecies, points of honor, and habits of order; the custom of sending ward patients away as soon

as their recovery is sufficient to permit it—these are features of management likely to be misunderstood. A reasonable explanation of them will often help to foster good feeling between hospital and public.

In order to co-operate wisely and effectively with other social workers in the city the hospital social worker must understand their several functions and work side by side with them. Thus will they too learn her duties. Moreover, it is only by keeping closely in touch with outside work, by reading current literature on social problems, and by seeing clearly her own task in its wide significance and the hospital as part of the social life of the city that she can continue to offer anything vital to the institution she represents. On the other hand, she should feel an obligation to see that there is a steady flow of her own vital experience with patients, back to the administrators, the nurses, and all others who are concerned with the sick, but whose duties keep them within the hospital walls. Without betraying confidences she can pass on something of the story of little "Tony," who was in the ward for months with osteomyelitis, or Mrs. Schwartz who was "such a very sick pneumonia case," or report the result of the conference with the Board of Health about the syphilitic patient who refused to return for treatment. Thus she can help to counteract those evils of institutionalism which are deadening to the finest hospital atmosphere. Nothing is more damaging to the

spirit of a social service department than that the worker should allow herself to fall into routine or stereotyped habits of thought or action. It is of prime importance, therefore, for the medical-social worker to keep herself from getting into habits that blind her to any aspects of the patient's life which are fresh and acute to the patient himself as he comes to a hospital for the first time. His dislike of smells, bare walls, white coats "like butchers," of being nursed by women not of his own family, his dismay at being given casual and indifferent answers to his questions, his fears that neighbors will find out what is written on the hospital record, are often not appreciated. By reminding herself constantly that each patient has many interests and ties other than those associated with his disease, the worker can preserve a fresh and vivid mind. Thus, while appreciating the attitude of the physician and of the hospital authorities, she must always keep clearly in mind the feelings of the patient whose representative she is.

In organizing her work it is wise for her to start her labors in that ward or that out-patient clinic in which she can most surely hope for response and enthusiastic co-operation from the medical staff. But from whatever point she starts, her final aim should be to have social service so permeate the institution as to lose any sharp delineation of its field. While she must always be the agent through whom the work is to be accomplished, the spirit of social service should become that "integrating

factor" that binds all functions of the hospital together. Alone she can never accomplish this; it must result from the co-operative effort of all concerned. To the social worker, however, the opportunity is presented of weaving together many of the strands.

Social service demands from workers a plastic organizing faculty. Nothing defined and preconceived can be superimposed upon a hospital or dispensary. Each medical institution is different from others in its organization and needs. Each worker must accept the situation as she finds it. A capacity for thinking clearly about it, for analyzing its elements, for discriminating between the essential and non-essential, for seeing the unique opportunities of her hospital for service, will help her to build a sound foundation.

Probably no question with regard to the choice of workers has been more discussed than that of the fitness of the trained nurse for hospital social work. While the value of her special knowledge is not called into question, there has been a difference of opinion as to her fitness for social work by virtue of her nurse's training alone. It is contended that since hospital social service deals with sick patients, she is peculiarly adapted for it. That she may have the ability to work smoothly with the other nurses and with doctors, keen human sympathies, and even a social point of view are granted, but that she can possess and use the technique of social work or acquire its accumulated knowledge

without having had experience or training in that field is obviously not probable.

After the technical clinical training which the nurse receives in two or three years of confining, arduous study and labor within hospital walls, she will require an understanding of the community and its resources, an appreciation of the various standards of living represented among hospital patients, familiarity with the habits and prejudices of different nationalities, and especially of the ideals and methods by which good social work is sustained. This knowledge and experience should be a part of her equipment before she can do a high grade of social work for a hospital.

There are fundamental differences between nursing and social work which it is well to recognize. The relation of a patient to a nurse is one of dependence. If a person is sick enough to need a nurse, he must be spared all responsibility and give himself up to the physician and nurse who care for him through his acute illness. Most nurses are not much interested in the convalescence of a patient. Their technical ability, which they naturally enjoy using, is no longer called upon. During a patient's adjustment to work and responsibilities his needs become changed. He must begin to depend on himself; the habit of dependence must be broken and an effort be made to help him get onto his feet. One who has done only nursing has had little preparation for this service, because patients rarely complete their convalescence in a hospital. When

a nurse no longer feels that the need of her personal, skilful aid is urgent, the inspiration for her work is gone. It is partly because of a natural characteristic, the desire to be needed, that women have been such successful nurses, and that nursing will always be one of the greatest professions open to them.

While social case work is by no means a greater or a nobler service, it has quite distinctive aims. Good case work is constructive, for its conscious aim is to release the energies of the individual in the best possible direction. It strives to give the man, dependent from whatever cause, new incentives to self-help and development. Herein lies the chief distinction between nursing as it is at present practiced in our hospitals and social work.

Again, from consideration of a patient as an isolated individual whose personal abnormality must be rectified, the social worker must learn to consider him in all his human relations. As a nurse, she must fix her attention on the troubles of one person alone; as a social worker, she must see the patient's illness as only part of a larger and more intricate difficulty—the key perhaps to a house of sorrows. The outlook becomes divergent rather than convergent, and new points of observation differing also in kind are required. This does not mean that nurses cannot and have not developed into excellent social workers. There are many such; but our training schools for nurses alone have not produced them. It would seem to be

axiomatic, therefore, that if a nurse is to do social work she should have social training, regardless of any valuable prerequisites that she may possess by virtue of her other training.

It should be made clear that in the above discussion I am not considering the visiting nurse who functions from a hospital—an extension of the medical service into the homes of patients. This service is very valuable and necessary in many communities where there is no centralized visiting nursing association to which the hospital can turn for such assistance, but it is not the kind under consideration here.

The nurse has not only to acquire new abilities but to overcome old tendencies, the result of her special education, before she can succeed in social work. The desirability of originality and initiative in social work is apparent. The instruction of the nurse, as it is carried on in the majority of our training schools, does not stimulate these powers, for a prolonged period of silent submission to discipline is characteristic of her training school experience. She does not learn to think independently, to dare, to lead. As a social worker, however, her position is not one of subservience to orders. Rather is it one of self-reliant judgment and planning in her own sphere. Her decision with regard to the social aspects of a situation, and her formulation of a plan of treatment, must be an independent contribution. The final decision will not rest wholly with her nor with the physician, but

will grow naturally out of the balancing of the two points of view. Neither takes orders from the other. To the nurse this situation requires new mental habits. She is no longer the doctor's medical assistant, but his consultant, called in as an expert from another field of service. The nursing profession is undoubtedly going through a period of change in methods of training. To what extent these changes will modify the product of the schools and the relations of nurses and medical practitioners, the future alone can tell.

The social worker who has no medical knowledge has much to learn concerning physical conditions before she can work intelligently. Such knowledge is, in fact, an important asset to the social worker wherever she is. There has been no adequate means of getting just the kind of medical knowledge that is needed except through practical experience in the clinics and by daily contact with those who have it and are able, in the course of the day's work, to pass it on. Time has shown that much of the technical bedside training of the nurse is unused in social work, and that much definite medical information—such as the causes and progress of disease, the treatment of long convalescence, the elements of sanitation, the multiform ramifications in special branches of medicine dealing with tuberculosis, contagion, hygiene, and public health methods are not emphasized in the nurse's training, though all are vitally important in social work.

The nursing profession is an outgrowth from the

medical profession. The medical subjects valuable to bedside service have been taught rather grudgingly to the nurse and have been supplemented by methods devised to make a patient more comfortable through her personal care. In the same way, the profession of hospital social work, which is neither medicine nor nursing, will have to receive from medicine the contribution vital to its new function, supplemented by a similar contribution from sociology. Workers so trained would have some comprehension of two professions, which would make them valuable in both medical and social problems, and helpful to the patient in his physical as well as in his social difficulties.

During the pioneer years of the hospital social service movement the urgency of the call, and the fact that there were few to answer caused social service departments to send out workers inadequately prepared, after only a few months of preliminary training, to establish similar departments in other hospitals. The lack of standards that has become apparent as a result of this indiscriminate use of untrained people has proved unfortunate in many instances. Nevertheless, a large measure of success has attended those hospital social workers who kept clear their purpose of service to the patient and have had the intelligence and flexibility to grow with their experience. They have met a need, although imperfectly, and have demonstrated the importance of personal offices supple-

mentary to the medical and nursing service that the hospital already afforded.

But the greatest fruits of these pioneer years have been the clarifying and deepening of the conception of the social needs of hospitals, and a very definite conviction that if the ideals of the service are to be fulfilled there must be more careful selection of the personnel of departmental staffs and a more adequate training provided.

Since 1912, courses of two years' training for hospital social work have been conducted at the Boston School of Social Work, and other opportunities for training have been offered, notably at the New York and the Philadelphia schools. These courses consist of a basic training in the general field of social work, both academic and practical, supplemented by an interpretation of social work as it is applied to hospitals and dispensaries.

Considerable attention is at present being given to working out a more adequate curriculum for the training of the hospital social worker both in her theoretical and practical preparation. According to the report of the survey made by the American Hospital Association in 1920[1] an adequate education for hospital social work should offer training and experience in the following subjects:

1. Knowledge of the chief diseases, groups of diseases, and health problems, primarily in their social implications.

[1] See "American Hospital Association Report of the Committee on the Survey of Hospital Social Service" published in *Hospital Social Service*, 1921, Vol. III, pp. 1–21.

2. Understanding of the social, industrial, and economic problems as they affect family life.

3. Knowledge of the purpose and activities of the chief public and private health and social agencies and of legal and community conditions which affect health.

4. Understanding of the traditions and customs of the medical profession and of medical institutions.

5. Ability to utilize both knowledge and personal qualities in attaining understanding of people and the practical results in co-operation, guidance and leadership.[1]

Of immeasurable importance to the future of hospital social work in this country is the report of the Committee on the Training of Hospital Social Workers of the American Hospital Association, which will be published in 1923, the results of a two-year study of the present methods of training for hospital social work. The Committee, which consisted of hospital administrators, hospital social workers, educators, teachers of social work, teachers of nursing, physicians, and psychiatrists, has made an unanimous recommendation of a two-year training period correlated with practical experience. The carefully prepared and suggestive curriculum thus presented will undoubtedly do much to raise the present training courses to a higher and more consistent standard. The American Association of Hospital Social Workers has undertaken to promote the program recommended by this committee.

In the interests of the future of the movement,

[1] Report of the Committee Making a Survey of Hospital Social Service, American Hospital Association, Bulletin No. 23, Chicago, November, 1920, pp. 9–10.

no question is more vital than that of the selection and adequate training of the workers to carry it on. The service, as it develops, must take form from the personality and intelligence of those who are molding it. For this reason the choice of workers, both paid and volunteer, is of prime importance. Those who are carefully selected for ability in organizing and interpreting the work, and who possess a balance of qualities fit to meet the multitudinous needs of the service with a never-failing spirit of sympathetic interest in the patients, will bring the best promise of success.

## VOLUNTEER SERVICE

While the distinction between paid service and volunteer is not necessarily synonymous with trained and untrained, the majority of those willing to give their services have usually some prior claim on their time, and how best to use what they can offer is one of the hospital social worker's responsibilities.

As previously stated, before professional social service was thought of as an integral part of hospital care, volunteers from laity and clergy had long visited sick patients, and by devoted personal service met their material and spiritual needs. The service of the volunteer, therefore, cannot be regarded as an innovation. Neither should we regard it as supplanted, but rather as made more effective through the advent of the professional social worker. In both hospital ward and in out-

patient clinic, the social worker, officially recognized as part of the staff and specially equipped to observe, can and does discern the needs of patients more accurately than can an untrained and intermittent volunteer. The trained worker, however, is in a position to discover many social difficulties that widen the horizon and increase the usefulness of the volunteer, who thus becomes more necessary than ever in a well-rounded medical-social program.

In some hospitals volunteer service in the wards has remained distinct from the social service department, the work of the professionals being largely confined to the dispensary and distinct from the friendly visiting in the ward. Such loose organization and such division between two groups interested primarily in patients in the same institution indicate a distinct weakness. Not only are overlapping and duplication likely, but each group misses the peculiar contribution which the other has to make. An organization by which the paid social worker, by virtue of her official position and special training, supervises and guides the work of the volunteers, ultimately brings the best results.

It would be difficult to estimate the measure of helpfulness that has been given by volunteers to social service departments. The enthusiasm and devotion with which they have co-operated with the trained workers have been a great stimulus and support to those who have carried the responsibility of the pioneer organization. Not only have

they helped materially in the day's work, but they have also conveyed to hospital authorities and to those in the community from whom support is drawn an appreciation of the importance of the department. Moreover, highly efficient social workers have been discovered and trained in the volunteer group.

In certain medical-social departments many volunteers have from the beginning been in close touch with the details of the service. Especially is this true at Bellevue Hospital, New York, the University of Pennsylvania Hospital, and the Barnes Hospital of St. Louis. They have worked shoulder to shoulder with paid workers.

There are several cautions to be observed, however, in the selection and direction of volunteers. In the first place, their number must not be too great to prevent careful supervision of their work. If the volunteer corps increases beyond the ability of the trained worker properly to supervise and develop its efficiency, it becomes a weakness rather than a strength. In cities where the hospital social work has become popular enough to excite the interest of many persons who can give their time, the professional worker can select from applicants those best adapted for the work.

Some may seek personal relations with patients, but may be fitted for statistical, clerical, or office work. In a certain department a volunteer assumed the tabulation of all routine statistics; another took charge of the catalogue of the patients'

addresses; many others have become clinical secretaries; some are well suited to interview patients or to visit them in their homes; some undertake correspondence with them, writing friendly letters to those who are leading a tedious existence in a sanatorium; others can provide bedside occupations or work in the hospital library. Those allowed to visit patients in their homes or to undertake any social case work should be particularly qualified for the work. It is only just to the patients and to volunteers to take pains in the latter's selection and in giving them tasks fitted to their abilities. Making them responsible for a piece of work and holding them to a high standard in it is by far the most satisfactory arrangement for all concerned. The volunteer, if she is the right sort, will appreciate this businesslike attitude. There is no satisfaction to the helper in doing poor work, nor in uselessly wandering along without guidance. Imagination on the part of a supervisor in discovering ways for employing the special gifts of her volunteers multiplies her own usefulness.

Promptness and regularity should be insisted upon with all workers, volunteer as well as paid. A schedule of the hours of volunteers is useful; and if these workers are to be of value it is indispensable that they should keep to their schedule. This is particularly true for those engaged in an office where desk room is limited, or whose work must be planned in advance. Those who make home visits, or arrange for the transfer of patients to an

institution for convalescents, need not be held so rigidly to stated hours.

The supervision of volunteers should be painstaking, especially of those who visit patients in their homes. Unless they have been thoroughly tested they should not be asked to take the full responsibility of vital decisions in such cases, even though no one else connected with the hospital comes in contact with the patient. To make such decisions would be unjust both to patient and to volunteer.

A helpful way of eliminating the repetition of personal instructions to new volunteers is to have a notebook of instructions and a policy book, as it is called, which contains the accumulated decisions affecting the conduct of the department. Each volunteer can peruse these when she first comes to the department and can consult them further from time to time. Information, such as the names of hospital officials and members of the social service department, hours for admission of patients and for visiting in wards, rules governing the care of records, the location of maps, street directories, writing supplies—in fact, any kind of information that should be common knowledge in the department and that will help to make its work simpler, will be suitable for such a book.

A weekly conference between volunteers and paid workers is an admirable way to give the former an insight into the principles that guide the activities of the department and its scope.

Many times the hospital worker feels the need of help from professions other than those available in the hospital—of the lawyer, minister, psychologist, and linguist. Every community has members of these and other professions ready to give volunteer service to those in trouble. It rests with the social worker to find them.

Sometimes students of medicine, of divinity, of economics, and students in schools for social workers have given useful volunteer service in the social service department of a hospital while obtaining valuable experience for themselves. Dr. Emerson's sending his medical students to visit families who had applied to the Baltimore Charity Organization Society (now Family Welfare Association) in order that they might get an appreciation of the environmental influences affecting their patients' lives, suggests a way of increasing the number of helpers. A divinity student offered several hours each week to a social service department, saying: "If I am to be any use in the ministry, I must know more intimately than I do the kinds of trouble that people have to meet. It seems to me that hospital social service would give me the best opportunity to know how to be of help in every kind of distress."

In New York, Boston, Philadelphia, Baltimore, and St. Louis students from the schools for social workers are assigned to hospitals for practical work. Such students thus gain experience analogous to that which the medical student has in the

hospital clinic. The amount received depends on the intelligence of the student and the kind of supervision given. In no hospital is there a dearth of valuable experience. Those that undertake to train students in social work, however, should be mindful that the instruction of students is the important consideration, not getting odd jobs done. Unless a department is prepared to give this vocational instruction it should not accept students. They should be accepted only with a serious recognition that they are the potential hospital social workers of the future.

# CHAPTER XII

## THE FUTURE OF HOSPITAL SOCIAL SERVICE

IN THE preceding pages I have tried to define hospital social work as it is gradually taking shape in many of the hospitals and dispensaries of the country, and in discussing its organization we have found that there is no longer any question of its legitimate place as an integral part of the hospital itself. A look into the future shows us hospital social work inextricably tied up with the hospital. But since under certain conditions this close connection may mean rigidity and limitation of growth, why is it that those interested in the movement welcome the identification of the social service department with the hospital organization? Is there not danger that this semi-military, conservative institution with its long traditions of procedure may overwhelm the spirit and check the performance of this new form of service? Yes, there may be such dangers. Nevertheless, there is reason for facing the future with great faith and hope, because the modern hospital is not a static institution.

Material equipment and housekeeping have

largely been standardized, but a new forward-looking spirit is impelling leading administrators to see far beyond hospital walls to the community that the institution serves. Such men as Dr. S. S. Goldwater, Dr. Frank E. Sampson, Dr. R. G. Broderick, Dr. Willard C. Rappleye have visions of a hospital of the future that will not only give adequate care to each patient, but will also carefully adapt institutional facilities to meet the changing needs of organized medical service in the community. The recently published report on the training of hospital executives declares:

> The unit of operation of the hospital about which the whole organization should be built, upon which all activities must ultimately converge and constituting the reason for the existence of the hospital and professional groups working within it, is the patient. Only through him and contacts arising therefrom can the hospital find its fullest expression of service. A patient in the last analysis is only a human being either with or threatened with incapacity, physical or mental. He represents the cross-section of a human life and as such is the resultant of many forces in the past—hereditary, industrial, environmental, economic, social—which may have conspired to predispose or contribute to his present condition. It is frequently quite as necessary, then, to understand and to interpret these human and social factors as it is to appraise technical and biological factors in order to secure a correct diagnosis, to guide treatment intelligently and to propose methods of prevention. The administration of a hospital under this conception must necessarily be based on the community as the unit of operation, not the institution.[1]

[1] Principles of Hospital Administration and the Training of Hospital Executives, Report of the Committee on the Training of Hospital Executives, April, 1922.

We find architects and administrators striving to make the hospital less grim and forbidding. Even the bare, stark, white walls seem doomed, to be supplanted in time by pleasing colors. A few hospitals have a "hostess" at the entrance. All these attempts to think in the terms of a patient and his psychological reactions are welcomed by hospital social workers whose duty it has been to think primarily in those terms. The germs of social service are thus finding expression through more enlightened institutional administration, and organization is seen to be a flexible and living thing when guided to serve the patients more intelligently.

The survey of social service departments made by the American Hospital Association (1920) revealed a most astonishing array of activities now being carried on under the name of hospital social work. Some of these are undoubtedly a necessary part of any social work that aims to make the medical care of a patient more adequate; but many of them indicate that hospital social workers have given much time to patching up poor dispensary machinery, and inadequate nursing and clerical service. While some of this assistance is due to the generous desire of workers to be useful, it must be admitted that it is also partly attributable to lack of clear thinking by administrators. Better standards of hospital and dispensary administration ought to mean a clarifying of special

functions and a more intelligent and harmonious correlation of the various departments.

We must not put the responsibility for clear thinking on this subject entirely upon hospital administrators. Nor must we forget that if, in the process of bettering our technique and more clearly defining our office, we sacrifice any of the spiritual quality that has characterized the pioneering period of the movement, we shall have sacrificed that without which a social service department is unworthy of its name.

The properly run hospital of the future will give an opportunity for self-expression to each department that has a special service to perform. We must therefore ask ourselves to consider carefully what we have to give and how that service can best be related to other activities in the institution. We have accepted the principle that the function of hospital social work is primarily that of social case work correlated with medical care of the patient. But I do not conceive of this as discharging the whole business of a social service department. Social interest and impulse may express itself in several ways.

Miss Richmond has made a suggestive classification of social work into four forms—*social case work*, which deals with the social problems of individuals or families; *social work with groups*, such as we see in the neighborhood associations, settlements, and clubs; the mass work of *social reform*, expressing itself in social propaganda and legisla-

tion; and finally, *social research*. A hospital offers an opportunity for all four of these types of work. Case work we have recognized as fundamental to a social service department. To an increasing extent the future will see the other three forms in close interplay with case work in the hospitals that have effective social service departments. There has been already ample demonstration of the group or "class" treatment of many chronic diseases, such as tuberculosis, diabetes, nutritional conditions, and cardiac disease. While it is important to have some social facts about all patients, not every one of them needs social case work. But the psychological effect of the groups meeting regularly and the economy of this method of maintaining consistent supervision are now well recognized.

Hospitals and dispensaries have already yielded data of importance to promote social welfare. For instance, accumulated medical-social records of babies with ophthalmia neonatorum admitted to the ward of the Massachusetts Charitable Eye and Ear Infirmary, gave evidence of need for much more rigid enforcement of the law which requires immediate reporting of infected eyes in babies and for drastic action in cases of medical neglect. The report of this study was reprinted and widely distributed by the State Board of Health. By a similar method the needs of deaf children have been brought to the attention of the State Department of Education, and the lack of suitable insti-

tutional care for non-pulmonary tuberculosis patients has been demonstrated to the proper authorities. Many other instances might be cited.

Beginnings have also been made in social research within the social service department, the best of these having been undertaken jointly with physicians. A careful study of the medical situation is thus correlated with the social analysis.[1] I venture to predict that social research will find a fruitful field and reach a high level of quality in hospitals and dispensaries where, under the influence and with the co-operation of medical men of scientific attainments, social workers will acquire something of the standards that these highly trained practitioners set for themselves, and that we may in time approach a method of analysis of social ills worthy of the term "research."

Janet Thornton has made a searching analysis of all hospital activities with a view to fixing the bounds of hospital social work and establishing its relation to the other processes of the hospital.[2] She maintains, in this valuable contribution to our subject, that many hospital functions are social in character, and that not all of these are within the social worker's province. Further to strengthen that province, we need to develop those aspects

[1] For example, Ordway, Mabel and Ryther, Margherita: "Economic Efficiency of Epileptic Patients," *Journal of Nervous and Mental Disease*, Vol. XLVII, No. 5, May, 1918, pp. 321–342.

[2] Thornton, Janet: "Hospital Social Service as it Relates to the Administration of Dispensaries," Transactions of the American Hospital Association, 1921, Vol. XXIII, pp. 231–240.

of social treatment which are specifically concerned with the personal and environmental condition of the patient. Only when we have improved the quality of this specific service can we interpret it effectively to others within the hospital, whose tasks are also social, though social in a less technical sense.

## HOSPITAL SOCIAL SERVICE AND MEDICINE

The hospital physician finds it more and more impossible to ignore the psychological and social elements in his patient's troubles. He recognizes that he cannot treat a disease of the kidneys without reference to the heart, the digestion, and the nervous system. He is beginning to see that he cannot treat headache without a knowledge of a man's work, home conditions, sleeping habits, and economic anxieties. The physician will not become a social worker in the technical sense, but he will use the methods of this closely related profession more and more freely. The new light hospital social work has thrown upon the practice of medicine is most strikingly exemplified in psychiatry; but other branches of medicine, especially pediatrics and orthopedic surgery, as practised in hospitals and dispensaries, are being modified by the extension of hospital social service.

The terms "medical sociology" and "social medicine" are appearing with more and more frequency in medical and social work literature. Courses in "social medicine" are being offered in

schools of social work. Although the term is vague, it is suggestive of that new trend in medicine which is so closely interwoven with social work in various forms. The public health movements proclaim their absolute dependence on a public educated to share responsibility with the medical profession. Hospital social work has in part promoted this interrelation of medicine and social work and has in part been stimulated by it.

The study of diseases directly due to industrial processes and to the effects of industrial life on the worker has been tremendously stimulated during the war. These subjects are claiming the serious attention of physicians and sociologists as well as of managers of industry. Some investigations of adverse industrial conditions as they affect the health of the worker are best made in the workshop. The new demand for industrial physicians and nurses gives evidence of this. But other fields for study should not be ignored. Hospitals and dispensaries are continually caring for men, women, and children whose ill-health may be due to, or influenced by, the stress or special hazards encountered in their employment. The hospital social worker as agent of the socially conscious hospital, reflecting the scientific attitude of the medical profession and bringing to medical conditions her special knowledge, has an opportunity for research which has not yet been fully appreciated.

In one hospital, social workers, prompted by

their knowledge of the tragedy wrought by chronic lead poisoning in a few cases, made a study of a series of patients similarly affected who had been treated at the hospital. It was found that during a period of five years, 147 such cases had been treated. A preliminary study of the medical records showed the lack of important social facts in these cases, but also indicated the unusual opportunity that medical institutions have for learning the social importance of certain diseases. If accurate description of all occupational processes could be obtained in cases of lead poisoning, hospitals could offer valuable material to those who are seeking for better labor legislation and the enforcement of laws on industrial hygiene. "Laborer" means nothing to a physician who is examining a specimen of blood that discloses a "marked stippling." This suggests, of course, a diagnosis of lead poisoning, but when he learns that this laborer is a scaler of paint in the hold of ships in the navy yard, he has evidence that his diagnosis is correct. Also a consciousness on the part of physicians of the relation between diagnosis and a patient's occupation might make it probable that no one treated for lead poisoning would leave the hospital without knowing the basic cause of his illness.

In research, as in all other aspects of hospital social service, the foundation of careful medical work is essential. With this as a basis, the hospital social worker who, in the spirit of scientific medi-

cine, seeks the social background of disease should be able to help considerably in the progress of medical sociology.

## HOSPITAL SOCIAL SERVICE AND THE MEDICAL STUDENT

All progressive movements for public health and social welfare need the socially minded physician. Such physicians have been leaders in the campaigns against tuberculosis, venereal diseases, infant mortality, and occupational disease. The social-mindedness of doctors, however, is not given them by their medical training. Rather do they get it, if at all, through their natural interests and the conviction, forced upon them by years of practice, that medicine and sociology cannot be divorced. Society should not have to depend upon the chance production of this most valuable type of physician; the medical schools should assume responsibility for training them. While the schools cannot have courses in psychology and sociology, they might demand these subjects as prerequisite to medical training. But clinical teachers, if they have the social point of view and recognize the social service department as a laboratory from which they may secure important clinical data, can so bring out the significance of social facts in the cases studied with medical students that the student will be forced to recognize the inseparableness of the medical and social elements in disease.

Such a teacher is Dr. Charles P. Emerson, Dean

of the Indiana School of Medicine, whose clinics held in the Medical School at Indianapolis often develop into social conferences which are as interesting to the students as any part of their technical training. The social service department of the dispensary, in which the medical students receive their clinical experience, is affiliated with the department of sociology of Indiana University. Junior medical students are required to take one semester in the social service department with one hour's lecture each week and a home visit. Meantime all the clinic work is in the dispensary, where there is close contact with the social service department, as that part of the clinic to which the doctors logically turn for family history, for reports on conditions at home, and for assurance that the home treatment is carried out.

The senior medical students see this same close interrelation of medical and social work in the hospital, where the head social worker makes rounds with the medical staff and is held responsible for reports on "family history and environmental conditions which are considered essential information for medical diagnosis and treatment of a case." She makes her report as the representative of any other department would, and the importance of this procedure is emphasized to the medical students by the clinicians.

One morning the conference discussed the case of a girl with chlorosis, for whom little had been done medically beyond the ordering of iron pills.

The student who offered to undertake the supervision of this patient's treatment (the medical students often volunteer for such service) found the girl working in a laundry where she was standing all day on a wet floor and feeding wet clothes into a mangle. She took a cold lunch to the laundry, and outside of working hours helped with the housework at home. The patient slept with her grandmother, who had a prejudice against "night air." The discussion of such a case as this impresses upon the student, as no text-book can, the futility of medical, when unrelated to social, treatment. While supervising the medical care of a case, the student's experience constantly teaches him the medical and social interrelations in the causation, the prognosis, and the cure of disease.

It is necessary closely to relate instruction in the mental and social elements of a patient's condition to the clinical consideration of his disease. By making use of clinical material as a means of broadening a student's outlook on medicine, it is possible not only to teach him to be a better physician but also to emphasize his professional relations to the community's health agencies. If, while he was following the treatment of a case of typhoid in his private practice, he could at the same time know the trail to the source of his patient's infection, his eyes would be opened to the importance of a pure milk supply for the general public and to some of the functions of a board of health. Social service departments in hospitals

or dispensaries affiliated with medical schools have a unique opportunity to bring clearly before students the inevitable complexity of the patient's physical, mental, and social conditions and to assist in the social interpretation of medicine.

## HOSPITAL SOCIAL SERVICE AND THE NURSE

In the preceding chapter I pointed out that the teaching of nursing as an art encounters many difficulties due to the pressure of work and the restricted life of the pupil nurse in most of our big hospital training schools. The technical and academic preparation of the nurse for her profession has not suffered so much as has her training in the social aspects of the service. Hospital nurses as well as doctors have lost, under the stress of work and the complications of organized medical service, some perception of the patient as a whole man. Many thoughtful superintendents of nurses have been troubled by this, especially since they realize the rapidly developing opportunities for the graduate nurse in public health work, for which the three years of life in a hospital does not prepare her either in her point of view or in her technique. We have, therefore, seen a most significant tendency among training schools for nurses in hospitals with well organized social service departments to use these latter as laboratories in which to give the nurses an interpretation of the personal and social background of hospital patients. Women entering training schools pre-

sumably bring to their experience a keen desire for service and a love of people. Their point of view at entrance is that of individuals fresh from community life. Because the hospital is to them strange and possibly a bit overwhelming, they appreciate then better than ever again the impressions and feelings of the patient who is entering a hospital. In 1914 Lillian Clayton,[1] at that time superintendent of nurses at Cook County Hospital in Chicago, urged that advantage be taken of this psychological moment to send probationers to the social service department for a week before they became absorbed in work in the ward, in order to give them a vivid impression of the background of the hospital population and of the crowded and unwholesome homes from which patients of that great hospital came. Miss Clayton put her ideas into practice and established an affiliation with the social service department, by means of which probationers visited the homes of a number of patients and various institutions, such as the almshouses, a foundling home, a convalescent home, a municipal lodging house, and a juvenile court. All these experiences were interpreted by the social worker. The aim was "to prepare students to nurse the patient with a more sympathetic attitude; to think of him as an individual and as a member of a household and so-

[1] See Clayton, Lillian: "Has the Training School any Responsibility for the Education of the Public Health Nurse?" Proceedings of the National League of Nursing Education, 1914, St. Louis, pp. 177–183.

ciety; to appreciate the causes underlying disease." Several hospitals have adopted Miss Clayton's idea with some modifications. In one hospital the head worker in the social service department gives to the probationers, during their first month, the history of the hospital in its social significance, the reason for its existence, its means of support from the community, and then an analysis of the patients it serves. The annual hospital report, with its statistics of nationalities, ages, residences, occupations, and groups of disease, offers an opportunity to make social interpretations to the nurses and can be made a basis for illustrating the part that social service plays in the effective treatment of people who have numerous handicaps.

Many hospitals extend to nurses in the second or third year a period of two or three months' full time in the social service department. In 1916 eighteen social service departments were giving this experience to pupil nurses. Practical observation under supervision of, and interpreted by, trained social workers gives them a vivid conception of the life of hospital patients and of the relation of the hospital to other city agencies working for better health or for the control and alleviation of disease. One of the pupil nurses who had this training testified that not only her social but her *medical* knowledge increased during the period. Many patients and diseases treated in the out-patient department were not admitted to the ward, and without the opportunity thus

offered would never have been seen by the nurses. The variety of experience and the awakening of the nurse to the efforts for social betterment give her not only a glimpse of new fields open to her if she feels called to that type of service, but make her more conscious of what is going on in the world about her, so that, as a young probationer declared, "even the newspapers are more interesting."

## HOSPITAL SOCIAL SERVICE AND THE SOCIAL WORKER

Possibly no one has welcomed the hospital social worker more heartily than the social worker outside the hospital. Except for an occasional fear that hospital work might overlap that of the family welfare agencies and cause confusion from which their clients would suffer, there has been a general recognition of the significance of this new field and an appreciation of the help which the social worker within the hospital might give to those without.

She can interpret to the worker outside the technical and cryptic information given out by the physicians about the patients sent to the dispensary clinics; she can also advise her as to the needs of patients discharged from the wards. Such knowledge as she can give is often necessary to a plan for the man seeking some other form of assistance.[1]

The relation of disease to other social ills is no new idea to social workers, but they need much

[1] See Chapter VIII.

more definite knowledge of physical conditions.[1] Also from the doctor they have much to learn concerning the subtler relations between physical sufferings and social maladjustments. What the hospital social workers thus learn they can pass on to social workers outside. Such an exchange enlarges the community's understanding of the influence of sickness on character, of the pathological effects of fatigue and malnutrition, of the preventive and curative use of hygienic measures, of the value of suitable diet and the limitations of moral responsibility in the victims of wretched physique. In future plans for the socially afflicted there will be fewer failures traceable to ignorance of the physical background.

In some cases the physical basis, which has been wholly ignored, may be the chief cause for the particular disaster. An illustration of this truth is given in the fourth annual report of social work at the Massachusetts Charitable Eye and Ear Infirmary, Boston. The report reads:

"A man, forty-eight years of age, was sent to us one day, ragged, emaciated, almost helpless without his glasses which had been broken a few days before. His record with the public and private charities of Boston and other cities was a very bad one—idleness, drink, immorality, neglect of his children. The hospital found a condition of high myopia, which had been corrected only after the man had passed his twenty-fifth year, when he had thoroughly learned the lesson of idleness; the rest had followed easily. All his life he had been handicapped;

[1] See Richmond, Mary E.: Social Diagnosis, p. 204. New York, Russell Sage Foundation, 1917.

in school, when his fellow-pupils who had better vision left him far behind; later, when work was difficult to find and, for him, almost impossible to keep; and later still, after glasses had been found to help his vision, by the habit of idleness and its attendant evils acquired through little fault of his own. There was no doubt about his very bad record, but the hospital finding left much doubt as to his individual responsibility for it. Though our report could, of course, make no difference in the action of any charitable society in such a case, as present conditions must govern action, it would essentially change the attitude and modify the message to the public in regard to this physical misfit."

The future of social work in hospitals must in the last analysis rest with the professional workers who, as time goes on, will assume in increasing numbers their privileges and duties in the social service departments of the country. More adequate training facilities and higher standards of admission to training courses for hospital social work are essential to securing a high grade personnel. The American Association of Hospital Social Workers, organized in 1918, is a body which from the first has realized that the chief responsibilities must rest with workers themselves, although the success of the movement requires cordial reciprocal relations with many others. It is generally accepted that, while the principles of hospital social work should be firmly held, their application to various types of hospitals in many different communities must be practical and pliant. This is no sign of weakness, but evidence of capacity for growth. We must not resist

changes, new adaptations, new and deeper evidence of our interdependence with hospital administration, with medical progress and with the growth of social work itself, for we have been counselled by many of our wise guides that "in proportion to our relatedness are we strong."

# APPENDIX

## FORMS AND FACSIMILES

REFERRED TO SOCIAL SERVICE DEPT

BY DR. Lee

Reason referred (*i. e.* what does the patient need?)

Patient has been "fluttering around" In my opinion she has definite tuberculosis (slight) She needs an iron tonic & sanatorium treatment.

Roger S. Lee.

REFERRED TO SOCIAL SERVICE DEPT.

BY DR. Waterman

Reason referred (*i. e.* what does the patient need?)

This patient tells us stories of abuse at home by his sons. He is depressed and moody. Can you tell us what the conditions are there?

REFERRED TO SOCIAL SERVICE DEPT.

BY DR. Badger

Reason referred (*i. e.* what does the patient need?)

She is overworked, and tired. Works all day in a candy store, and at home nights. Can you arrange for her a better day? She needs help. Do not definitely tuberculous, but will report to us from time to time for further examination.

REFERRED TO SOCIAL SERVICE DEPT

BY DR. Mead

Reason referred (*i. e.* what does the patient need?)

Annie Kann needs a corset belt. But says she is unable to pay for it. It was recommended for her 2 years ago. & never has had money enough to get it. I imagine her husband needs bracing up.

**Massachusetts General Hospital—Social Service Department**

Referred by Society for Prevention of Cruelty to Children, Beverly Date July 13, 1912.

Name Harry Elmore

Address 25 Cross St., Beverly S. M. W. R. Age 39

Nationality American

Birthplace Beverly

Previous medical treatment (place): (When)
Dr. Allen, Private physician - last winter
Beverly Hospital, Dec. 5, 1911 - 3 weeks

Significant facts in family history—physical and social:
Uncle epileptic, feeble minded, epilepsy in wife's family; wife high-strung, neurotic; son Ralph, 14 yrs., wayward, untruthful, ran away from home Intermittent relief care.

Significant facts in patient's history—physical and social:
Family physician says diagnosis last winter, "physical exhaustion" for want of better term Beverly Hospital diagnoses "debility" last winter. Man so sick has had to give up work at times and go to bed Worried about financial condition and conduct of son

Employment

Nature Factory Hand Place United Shoe Machinery Co, Beverly Hours 51 hrs wk

Reason for referring:
Is man able to work? Does he need hospital or convalescent care?

**To the Clinic Physician:**

The Social Service Department respectfully requests the following information:

Diagnosis Possibly tuberculosis - To be investigated further.

Prognosis Cannot give prognosis until diagnosis decided upon.

Suggestions (wherein Social Service or referring agency may co-operate):
This pt. has signs of a possible tuberculosis and must return with sputum and for further observation
Can you keep track of him and put the Beverly Charities on his trail if in two weeks he has not returned to us?

FORM USED BY AGENCIES REFERRING PATIENTS TO DISPENSARIES FOR REPORT OF PHYSICAL CONDITIONS THROUGH A SOCIAL SERVICE DEPARTMENT

**BOSTON DISPENSARY** **SOCIAL SERVICE DEPARTMENT**

**Referred by** Associated Charities **Date** Nov-14-1912

Fees to be remitted · Yes ~~No~~

**Name** Tony Da M— S. ~~M. W. D.~~ **Age** 13

**Address** 70 Hunty Court City **Nationality** Sicilian

How long in U. S. A. 5 yrs

**Faith** Roman Catholic " " " Boston 5 yrs

**Employment** **Hours Daily**

**Nature School** hours at present. Formerly Place in father's Cobbler Shop — Grade

**Significant Facts in Family History. Physical and Social.**

Eldest of ten children, of whom nine are living. Sisters 13, now in Holy Ghost Hospital recovering from tbc of lungs and glands of neck. Bro 6 yrs at Childrens Hospital, rickets. Baby of 1½ yrs died in June of spinal meningitis. 6 other children in excellent health.

**Health Record of Patient**

Is probably good. He tells of Eruptious diseases up to present one, eczema a year ago.

**Previous Medical Treatment.** *Places and Dates*

None —

**Reasons for Referring**

For such medical treatment as is needed, and a report of doctors instructions.

FORM USED BY AGENCIES REFERRING PATIENTS TO DISPENSARIES FOR REPORT OF PHYSICAL CONDITIONS THROUGH A SOCIAL SERVICE DEPARTMENT

Folder No. 566

Dist. No._____ Date *January 29, 1921*

## (A) INFORMATION NEEDED FROM THE JEWISH SOCIAL SERVICE BUREAU FOR THE DISPENSARY

| 1. Name of Patient | Address | Age | Dispensary Number |
|---|---|---|---|
| Sam Simon | 1015 So. Paulina St. | 33 yrs. | 67360 |

2. Patient's complaint and symptoms

He cannot eat, has no natural elimination and is compelled to resort to the use of daily syringes. He has been sick for 3 months.

3. Previous illness or defects of Patient

When patient was about 16 years old, he was laid up with a fever for 14 weeks. Three years ago, was examined at C. F. D. and advised to go to hospital, but he did not do so.

4. Work history if Adult OR School record if in School

(a) Present employment (a) Grade

1. Type of work

Carpenter. Works for himself. Is mostly outdoors.

(b) Cause of Backwardness

(b) Previous employment—significant facts

When 12 years old, he learned the cabinet-making trade, which he followed for about 12 years, until he came to this country.

5. Medical Aspects of Family Diagnosis Treatment

Other members of family examined at dispensary and found to be in good condition.

6. Home Conditions

(a) Physical (b) Social

Father, mother and three children—10 years to 15 months—occupy four large, light, airy rooms, 3d floor front. No porches. Occasional friction.

7. Significant points in family history:

Mr. Simon came to this country 9 years ago, leaving his wife and oldest child in Russia. He did not succeed financially and therefore could not send for his family. During the war, his wife fled from Russia and, after a journey of 5 months, she came to this country in 1917. Mr. Simon managed to provide for his family, although he was sick occasionally. For the last 4 months, he has not had much work and at present feels too sick to do anything.

8. Primary reasons for referring to dispensary

The family was reported to us since Mr. Simon is sick. Kindly let us know the diagnosis and whether Mr. Simon is able to work.

FORM A USED BY JEWISH SOCIAL SERVICE BUREAU WHEN REFERRING PATIENTS FOR EXAMINATION TO MICHAEL REESE DISPENSARY, CHICAGO

Patient studied up to February 9th

(B) SPECIAL INFORMATION WANTED BY J. S. S. B. FROM DISPENSARY

1. Diagnosis: Date of Examination *February 11, 1921*
   Constipation (Properitoneal hernia).
2. Physician's recommendation and interpretation
   (a) Cause
   Mainly improper living—poor food—nervous influences.
   (b) Recommendation
   1. Rest
   Not needed.
   2. Recreation
   Greatly needed—anything that would interest patient.
   3. Diet
   Coarse and anti-constipation (cereals, fruit, vegetables—limit of meat). Nutri. clinic to give instructions.
   (c) Other clinical references
   None.
3. Prognosis
   Good.
4. Working Capacity
   (a) May Patient continue present work? *Yes.*
   (b) Full time? *Yes.* Hours per day *8 or more.*
   (c) Kind of Work recommended
   Carpentry if patient prefers it. Any work that will absorb patient essential.
5. Remarks:
   Patient apparently is in a vicious circle of nervousness, constipation and economic difficulties. One reservation necessary as to diagnosis (obstruction) but this should be eliminated in a week or two of proper treatment. X-ray fails to reveal any organic lesion. Re-establish family and patient's complaints of physical difficulty might be expected to disappear. Our dietitian will visit in home and instruct wife about preparing of proper food. Patient may begin work at once and report to dispensary on Saturday afternoon if this does not interfere with his work.

   Signed—Dr. S. Strouse, Medical Clinic.
   Celia Tosman, Social Worker.

FORM B (REVERSE OF FORM A) USED IN REPORTING TO JEWISH SOCIAL SERVICE BUREAU RESULTS OF EXAMINATION OF PATIENT AT MICHAEL REESE DISPENSARY, CHICAGO

# Massachusetts General Hospital HOUSE O. P. D. Social Service Department S. S. No. 2189 O. P. D. No. 318765

Name Di Rosa, Carmella — Date of birth June 1-1877 — Birthplace Italy — Color or Race White — S. M. W. D.

Address 317 North St. Boston — Flights 2 F.H. — No. Rooms 5 — Rent No. Rooms $18.00

How long in U. S. 28 yrs. — In Boston - 20 yrs. — Settlement Boston — Citizen —

Religion R. C. — Church St. Mary's — Mother Tongue Italian

Industry — — Occupation Housewife — Employer — — Wage —

School — — Grade — — Insurance Metropolitan — Benefit $200.00 — Dues .10 per wk.

| FAMILY | KIN | DATE BIRTH | BIRTHPLACE | ADDRESS | OCCUPATION OR SCHOOL | WAGE | O.P.D. No. | INSURANCE Dues | INSURANCE Benefits |
|---|---|---|---|---|---|---|---|---|---|
| Carmella | pt. | 1877 | Italy | 317 North St. | Housewife | — | 318765 | .10 | $100.00 |
| Bruno | hus. | 1871 | " | " " " | Laborer | 21.00 | — | " | " |
| Salvatore | son | 1903 | Boston, Mass | " " " | messenger | 12.00 | — | " | " |
| Maria | dau. | 1905 | - - | " " " | chocolate dipper | 13.00 | — | " | " |
| Giuseppe | son | 1908 | " " | " " " | 7th grade - Lincoln School | - | - | - | - |

Diagnosis Lobar Pneumonia — C. E. of I. yes.

A. C. North End - 1918

S. P. C. C. 1918

Referred from Ward 16 — By H. O. Law

For Convalescent care

Date Referred December 22 - 1919 — 1st Visit to O. P. D. December 10-1919 — Interested Individuals

Date Adm. House December 10 - 1919 — Referred by O. P. D. or M. D.

Date Discharge December 31 - 1919 — Discharged to O. P. D.

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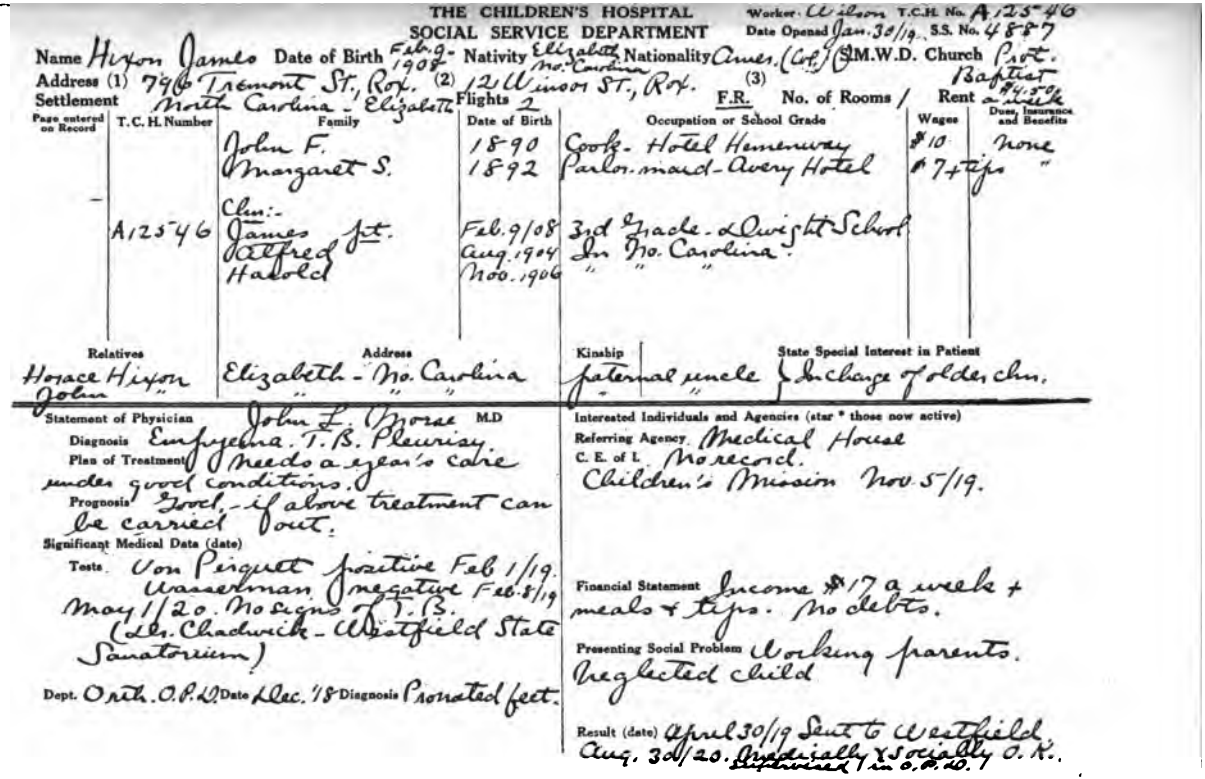
FACE SHEET USED IN SOCIAL RECORDS AT THE MASSACHUSETTS GENERAL HOSPITAL



THE CHILDREN'S HOSPITAL
SOCIAL SERVICE DEPARTMENT

Worker Wilson T.C.H. No. A12546
Date Opened Jan. 30/19 S.S. No. 4887

Name Hixon James Date of Birth Feb. 9-1908 Nativity Elizabeth, No. Carolina Nationality Amer. (Col.) M.W.D. Church Prot. Baptist

Address (1) 796 Tremont St., Rox. (2) 12 Winsor St., Rox. (3)

Settlement North Carolina - Elizabeth Flights 2 F.R. No. of Rooms / Rent $4.50 a week

| Page entered on Record | T. C. H. Number | Family | Date of Birth | Occupation or School Grade | Wages | Dues, Insurance and Benefits |
|---|---|---|---|---|---|---|
| | | John F. | 1890 | Cook - Hotel Hemenway | $10 | None |
| | | Margaret S. | 1892 | Parlor maid - Avery Hotel | $7 + tips | " |
| | | Clm:- | | | | |
| | A12546 | James Jr. | Feb. 9/08 | 3rd Grade - Dwight School | | |
| | | Alfred | Aug. 1904 | In No. Carolina | | |
| | | Harold | Nov. 1906 | " " " | | |

| Relatives | Address | Kinship | State Special Interest in Patient |
|---|---|---|---|
| Horace Hixon | Elizabeth - No. Carolina | paternal uncle | In charge of older chn. |
| John " | " " " | | |

Statement of Physician John L. Morse M.D

Diagnosis Empyema. T.B. Pleurisy.

Plan of Treatment Needs a year's care under good conditions.

Prognosis Good, - if above treatment can be carried out.

Significant Medical Data (date)

Tests Von Pirquet positive Feb 1/19. Wasserman negative Feb. 8/19 May 1/20. No signs of T.B. (Dr. Chadwick - Westfield State Sanatorium)

Dept. Orth. O.P.D. Date Dec. '18 Diagnosis Pronated feet.

Interested Individuals and Agencies (star * those now active)

Referring Agency Medical House

C. E. of I. No record.

Children's Mission Nov. 5/19.

Financial Statement Income $17 a week + meals + tips. No debts.

Presenting Social Problem Working parents. Neglected child

Result (date) April 30/19 Sent to Westfield Aug. 30/20. Physically & Socially O.K. ~~Discharged from O.P.D.~~

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FACE SHEET USED IN SOCIAL RECORDS AT BOSTON CHILDREN'S HOSPITAL

## SOCIAL SERVICE DEPARTMENT—PRESBYTERIAN HOSPITAL

SURNAME Lane NO. 8510

ADDRESS 414 Western Ave. DATE 9-1-20

CROSS REFERENCE

| KEY NO. | MEMBERS OF HOUSEHOLD | PATIENT | RELATION TO NUMBER 2 | AGE OR DATE OF BIRTH | SEX | CONJUGAL CONDITION | NATIVITY | NATIONALITY | TIME IN U.S. | TIME IN CITY | CITIZENSHIP | RELIGION | PRESENT HEALTH OR CHRONIC CONDITIONS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Thomas | | husband | 46 | M | M | Pa. | Amer. | L | 30 | ✓ | P | well |
| 2 | Bertha Quinn | ✓ | | 41 | F | M | Phila | " | L | L | ✓ | P | Goitre |
| 3 | Peter | ✓ | son | 8-2-99 | M | S | " | " | " | " | ✓ | P | Partially blind |
| 4 | Thomas | | son | 6-14-03 | M | S | " | " | " | " | ✓ | P | "Goitre" |
| 5 | Anna | | dau | 10-4-05 | F | S | " | " | " | " | ✓ | P | Over-weight. Cross-eyed |
| 6 | Sarah | | dau | 9-24-09 | F | S | " | " | " | " | ✓ | P | Well |
| 7 | Bertha | ✓ | dau | 7-6-12 | F | S | " | " | " | " | ✓ | P | Poor vision |
| 8 | (Mrs) Mary Quinn | | mother | 69 | F | W | USA | " | " | 45 | ✓ | P | "Diabetes" |

| | RELATIVES, REFERENCES, ETC. | RELATION OR CONNECTION | ADDRESS | KEY NO. | PREVIOUS MEDICAL HISTORY | | |
|---|---|---|---|---|---|---|---|
| | | | | | PLACE OF PREVIOUS TREATMENT | DATE | DIAGNOSIS |
| 2 | Mrs James Blank | sister | 321 S 19 Phila | 2 | Presb.H. | 1912 | Phlebitis |
| 4 | Edwin A. Stone | Employer | Apex Grocery, 14 N. 12 | 4 | M D | 1919 | "Goitre" |

## PRESENT MEDICAL TREATMENT

| | HOSPITAL | | | DISPENSARY | | | MEDICAL RECORD NO. | DIAGNOSIS |
|---|---|---|---|---|---|---|---|---|
| | WARD | DATE ADMITTED | DATE DISCHARGED | CLINIC | DATE ADMITTED | DATE DISCHARGED | | |
| 2 | | | | Surg. | 9-16-20 | | 34612 | Sprained ankle |
| 2 | | | | Med | 9-29-20 | | 50403 | Hyperthyroidism |
| 3 | | | | Eye | 8-4-20 | | 20014 | Choroid atrophy |
| 3 | | | | Med | 8-14-20 | | 106435 | Dyspituitarism |
| 7 | | | | Child. | 9-25-20 | | 86346 | |
| 7 | | | | Neurol. | 9-28-20 | | 33967 | Dystrophia adiposo-genitalis |

| | REFERRED BY | DATE | DOCTOR | WORKER | REASON REFERRED |
|---|---|---|---|---|---|
| 3 | Med. Disp., Dr. Thaw | 9-1-20 | Thaw | Howell | Arrangement for dentistry |

FACE SHEET USED IN SOCIAL RECORDS AT PRESBYTERIAN HOSPITAL, PHILADELPHIA. FORM ADOPTED BY ALL SOCIAL SERVICE DEPARTMENTS IN PHILADELPHIA HOSPITALS. (PREPARED BY THE BUREAU OF SOCIAL RESEARCH)

## Housing Conditions

| DATE | ADDRESS | TYPE OF HOUSE | NUMBER OF ROOMS | FLOOR | UNDERDRAINAGE | REPAIRS | CLEANLINESS | NO. OF PERSONS | LOCATION OF WATER | LOCATION OF TOILET | BATH | NO. OF LODGERS | YARD | COURT | DATE CONDITION REPORTED | COND'T CORRECTED | RENT | OWNER'S OR AGENT'S NAME AND ADDRESS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9-5-20 | 414 Western Ave | D | 6 | | Y | G | G | 8 | H | H | C | 0 | V | | | | $21. | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

| DATE | PREVIOUS RESIDENCE | DATE | PREVIOUS RESIDENCE |
|---|---|---|---|
| | | | |

## Work or School Record

| KEY NO. | PRESENT EMPLOYER OR SCHOOL ADDRESS | OCCUPATION TRADE PROCESS OR SCHOOL GRADE | HOURS PER DAY | HOURS PER WEEK | PRESENT WAGE PER WEEK | NORMAL WAGE PER WEEK | PRESENT INDUSTRY OR SCHOOL OR HOW LONG OUT OF WORK | AGE AT BEGIN'G WORK | PREVIOUS INDUSTRY OR SCHOOL | YEARS AT TRADE | SEASONAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Pennsylvania RR | Telegrapher | | | 25. | 25. | RR- | | | 26 | |
| 2 | Home | Housework | | | | | | | | | |
| 3 | U.S. P.O. | Mail Carrier | | | 25. | 25. | Post Office | | | 1 | |
| 4 | Apex Grocery, 44 N 17th | Driver | | | 18. | 18. | Grocery - retail | | | ½ | |
| 5 | Lit's Dpt. Store | Bundle-girl | | | 10. | 12. | Retail gen. merchs | | | 1 | |
| 6 | Western Sq | IV Gr. | | | | | Public School No 11 | | | | |
| 7 | " " | II Gr. | | | | | " " " | | | | |

| REGISTRATIONS | DATE | REGISTRATIONS | DATE | AGENCIES REFERRED TO | DATE | AGENCIES REFERRED TO | DATE |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## FINANCIAL STATUS OF FAMILY

| WEEKLY INCOME | DATE | AMOUNT | DATE | AMOUNT | DATE | AMOUNT | WEEKLY OUTGO | DATE | AMOUNT | DATE | AMOUNT | DATE | AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL WEEKLY WAGES | 9.1.20 | 62. | | | | | WEEKLY RENT — BOARD — LODGING | 9.1.20 | 40.+ | | | | |
| INCOME FROM LODGERS OR BOARDER | | | | | | | INSURANCE | | — | | | | |
| BENEFITS | | | | | | | OTHER OUTGO | | | | | | |
| WORKMENS COMP. | | | | | | | | | | | | | |
| OTHER SOURCES | | | | | | | | | | | | | |
| TOTAL WEEKLY INCOME | | 62. | | | | | TOTAL WEEKLY OUTGO | | | | | | |

FACE SHEET USED IN SOCIAL RECORDS AT THE PRESBYTERIAN HOSPITAL, PHILADELPHIA. FORM ADOPTED BY ALL SOCIAL SERVICE DEPARTMENTS IN PHILADELPHIA HOSPITALS. (REVERSE)

# BOSTON DISPENSARY

Page 1 Record No.

NAME Age. S.M.W.D Date 191

Address. Color B. D. No

Clinic { Old patient / Dates and clinics

Nationality Birthplace

Names of parents (or husband)

How long resident of U. S. A.

How long resident of Boston. Yrs. Mos.

OCCUPATION Earnings

Position

Where employed

How long in present occupation Previous occupations

NARRATIVE (based on interview at desk) *Bring out following points*

Patient's attitude toward Dispensary
What sent patient to Dispensary
Previous usual medical resource
O. P. D. (Where and for what)
Hospital (Ditto)
Private Doctor (G. P or Sp'Ts)

FORM USED FOR STUDY OF GROUP OF PATIENTS COMING TO THE BOSTON DISPENSARY (FACE)

## BOSTON DISPENSARY

Page 2 Record No.

HOME H. or T Floor F. or R. Rooms Occupants Rent, $ per wk.

Light Air Clean Tidy Sanitation

Sunlight Windows face on

Housing summary

HOUSEHOLD

| No. | Name | Date Birth | Place Birth | Occupation and Earnings |
|---|---|---|---|---|
| | | | | |

CHARITY Were B. D. fees paid Known C. E. of I.

Interested agencies

Financial aid

DIAGNOSIS as on record

Prescription as on record. Referred to S. S.

Treatment program as on record

Medical outcome as shown on record

FORM USED FOR STUDY OF GROUP OF PATIENTS COMING TO THE BOSTON DISPENSARY (REVERSE)

| Number persons | Family group | Ages | Diagnoses: Syphilis | ? Syphilis | Specific Parotitis | Scabies | Pediculosis | Urticaria | Eczema | Tonsilitis | Bronchitis | Constipation | Gingivitis | Sclera-Derma | Bleph. Conjunctivitis | Ichthyosis | Stomatitis | Phlyct. Keratitis | Adenoids & Tonsils | Rhinitis | Septic Thumb | Varicose Veins | Chronic Metritis | Cystic Degen. of Ovaries | No. of visits to Various Clinics: Skin | Children's | Female Medical | Female Surgical | Orthopedic | Nerve | Throat | Total no. of visits to O.P.D. | Cost to O.P.D. @ 45¢ per visit | No. of prescriptions | Cost of prescriptions | No. days in Hospital | Cost to Hosp. @ $2.52 per day | Total cost per Patient |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | fa | 42 | | ♥ | | ♥ | | | | | | | | | | | | | | | | | | | 2 | | | | | 1 | | 2 | $ .90 | 1 | $ .15 | | | $ 1.05 |
| 2 | mo | 40 | ♥ | | | ♥ | ♥ | | | | | | | | | | | | | | ♥ | ♥ | ♥ | ♥ | 27 | | | 2 | 2 | 2 | | 29 | 13.05 | 31 | 8.05 | 28 | $ 70.56 | 91.66 |
| 3 | da | 14 | | | | ♥ | ♥ | ♥ | | | | | | | | | | | | | | | | | 3 | | | | | | | 3 | 1.35 | 5 | .85 | | | 2.20 |
| 4 | da | 13 | | | | ♥ | ♥ | ♥ | | | | | | | ♥ | | | | | ♥ | | | | | 7 | 2 | 1 | | | | | 9 | 4.05 | 6 | 1.55 | | | 5.60 |
| 5 | da | 12 | | ♥ | | ♥ | | ♥ | | | | ♥ | | | | | | | | | | | | | 6 | 6 | | | | | | 8 | 7.20 | 8 | 2.05 | | | 9.25 |
| 6 | s. | 12 | ♥ | | | ♥ | | | ♥ | | | | | | | | | | | | | | | | 20 | | | | | | 1 | 29 | 12.60 | 24 | 6.20 | 21 | 52.92 | 71.72 |
| 7 | da | 11 | | ♥ | ♥ | ♥ | | ♥ | | | | | | | | | | ♥ | | | | | | | 9 | | | | | | | 9 | 4.05 | 5 | 1.15 | | | 5.20 |
| 8 | da | 10 | | | | ♥ | | | ♥ | | | | | ♥ | | ♥ | | | | | | | | | 8 | 2 | | | | | | 10 | 4.50 | 7 | 1.05 | 22 | 55.44 | 60.99 |
| 9 | da | 6 | | | | ♥ | | | | | | | | | | | | | | | | | | | 1 | | | | 1 | | | 1 | .45 | | | | | .45 |
| 10 | da | 3 | | | | ♥ | ♥ | ♥ | | ♥ | ♥ | ♥ | ♥ | | | | | ♥ | | ♥ | | | | | 4 | 2 | | | | | | 5 | 2.25 | 8 | 1.65 | | | 3.90 |
| 11 | s. | 3 | | | | ♥ | ♥ | ♥ | | | | | | | | | | | | | | | | | 6 | | | | | | | 5 | 2.25 | 6 | 1.00 | | | 3.25 |
| Totals | | | 2 | 3 | 1 | 11 | 7 | 4 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 102 | 12 | 3 | 3 | 3 | 1 | 1 | 110 | $52.65 | 101 | $23.70 | 71 | $178.92 | $255.27 |

ANALYSIS OF THE HOSPITAL EXPENSE INVOLVED IN FREE TREATMENT OF A FAMILY OF ELEVEN COMING TO THE HOSPITAL FOR A PERIOD OF THREE YEARS

# SURVEY—FEMALE MEDICAL CLINIC

New patients from to Sheet No.

Name S. M. W. Birthplace O. P. D. No.

Residence Occupation S. S. D. No.

**DIAGNOSES (WITH DATES OF EACH)**

Final

Provisional

Deferred

Date of 1st visit to O. P. D. Date of 1st visit F. M. Latest visit F. M. No. visits F. M.

Ref. from clinic (date) for exam., consultation, treatment No. visits

Ref. to " " " " " " " "

Trans. from " " " " " " " "

Trans. to " " " " " " " "

**EXAMINATION FEMALE MEDICAL CLINIC**

Physical exam.? Pelvic exam.? Rectal exam.? X-Ray?

Laboratory tests (check No. of each)

Urine Stool Stomach wash Hb. Blood smear

Vaginal smear Gon. fixation Wassermann

**TREATMENT**

Medicinal Dietary Gynæcological

Hygiene Zander Hydrotherapy

**CONDITION ON LATEST VISIT** **ATTENDANCE** **COMPLAINTS**

Well Regular Similar

Better Irregular New

Worse Advised to return

Referred to House? (date) Adm. to House? (date) Disch. from House? (date)

Date of subsequent visit to O. P. D. Notes on disch.

Condition noted Was advice given?

Ref. to other institutions? By whom?

Social data card?

Social record?

FORM USED FOR SURVEY OF MEDICAL RECORDS OF FEMALE MEDICAL CLINIC, MASSACHUSETTS GENERAL HOSPITAL

# INDEX

# INDEX